Management Information System Benefits to Management

January 25, 1979
Albuquerque, New Mexico

HEALTH CARE FINANCING ADMINISTRATION

MEDICAID MANAGEMENT INFORMATION SYSTEMS:

BENEFITS TO MANAGEMENT

Conference Summary

Sponsored by:

The Institute for Medicaid Management

Health Care Financing Administration

Department of Health, Education, and Welfare

JANUARY 23-25, 1979

ALBUQUERQUE, NEW MEXICO

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PREFACE

The Medicaid Bureau, Office of State Operations, Division of Information Systems sponsored a three day conference January 23-25, 1979 in Albuquerque, New Mexico. One hundred fifty-seven people attended the conference, representing thirty two States and the District of Columbia, ten HCFA Regional Offices, several HEW Washington offices, and twenty two private sector firms.

The purpose of the conference was to share successful management experiences (both State and Federal), resulting from effective use of management information systems. These experiences were shared through presentations by State and Federal staffs. The presentations stimulated interest and reactions as demonstrated by the questions and comments at the conclusion of each session.

Topics covered during the conference were pertinent, comprehensive, and generated enthusiasm for further formal and informal discussions. Exclusive of Federal moderators, there were a total of thirty speakers and panelists representing eighteen States, the Federal government, and five private sector firms. The conference, based on the overall reactions from attendees and participants, was a marked success.

The high point of the conference was a major policy address by Leonard Schaeffer, HCFA Administrator. Mr. Schaeffer outlined new directions for the Medicaid program and for MMIS. He stressed the need for more effective program management, citing MMIS as the best tool, and said program-oriented performance standards would be developed to measure results. He felt that program improvement is a State/Federal responsibility requiring flexibility and creativity on both parts.

The Inspector General's presentation on the lessons learned from Project Integrity and on the importance of MMIS as a tool to control fraud and abuse was very well received. There was significant interest generated in the establishment of an MMIS National Technical Advisory Group (NTAG). Major issues raised during the conference included:

1. Performance standards for approval and reapproval based upon effective utilization of management data provided by MMIS.

2. Commitment for Federal assistance to States in justifying resources for improved management.

3. Alternatives to the SUR subsystems.

4. Incremental and/or partial MMIS approvals.

5. Larger FFP match for smaller States to develop, design, and implement management systems.

6. Implementation of Section 17 (setting up State fraud, abuse, and waste units) has created an additional burden for program management in State agencies.

7. Increased emphasis needed on quality of health care.

8. Standardized definition of terms used in Medicaid/Medicare.

9. Tape-to-tape processing concerns:

   a. Original documents are needed for fraud and abuse prosecutions.

   b. Less manual scrutiny decreases chances for finding non-edit problems.

   c. Possibility of increased access to confidential data by unauthorized individuals.

This report is a compilation of major presentations made at the conference and also includes a summarized agenda and a list of participants.

SUMMARIZED AGENDA

MEDICAID MANAGEMENT INFORMATION SYSTEMS

BENEFITS TO MANAGEMENT

January 23 - 25, 1979

TOPIC	SPEAKER/PANEL
Welcome	Robert Silva, Acting Director Office of State Operations Medicaid Bureau, HCFA DHEW, Washington, D.C.
Introduction and Purpose	Richard Heim, Director Medicaid Bureau, HCFA DHEW, Washington, D.C.
Remarks	Larry Ingram, Secretary Department of Human Resources Santa Fe, New Mexico
A Funny Thing Happened on the Way to Certification	John Hall MMIS Project Director Department of Social and Rehabilitation Services Topeka, Kansas
The Need for Planning and Organizing for the Management of New Technology in a Public Agency	Bruce Kozlowski Director, MMIS Analysis and Development Division Office of Support Services Department of Social Services Lansing, Michigan
The Role of Management Systems in Combating Fraud, Abuse, and Waste	Ronald Schwartz, Deputy Assistant Inspector General for the Office of Health Care and Systems Review DHEW, Washington, D.C.
SUR as a Management Tool	Richard Heim, Moderator State Panel: Denise Chuckovich Bureau of Medical Assistance Division of Welfare Department of Social Services Boise, Idaho

TOPIC		SPEAKER/PANEL
		State Panel, cont.
*Texas:	Medicaid Eligibility Determination in Texas	Mary Awbrey, Chief Systems Development Bureau Department of Human Resources Austin, Texas
New Mexico:	BPST: Bill Processing System Test. A technique for system audit through the computer.	Richard Atkinson, Administrator Medical Assistance Department of Medical Assistance Santa Fe, New Mexico Larry Lawson Computer Systems Specialist Medicaid Regional Office Region VI, Dallas, Texas
Georgia:	MMIS Benefits	Robert Melvin, Director Information Systems Department of Medical Assistance Atlanta, Georgia
Nebraska:	In-house Development and Use of MMIS Data Base	Donald Hogg, Chief Medical Services Division Department of Public Welfare Lincoln, Nebraska Maureen Murray, Medical Data Processing Consultant Medical Services Division Department of Public Welfare Lincoln, Nebraska John Charles, Unit Manager Practitioner Unit Medical Services Division Department of Public Welfare Lincoln, Nebraska
California:	CURES: Cost and Utilization Analysis of Statistical and Management Information	Kay Moser, Chief Health Statistics Department of Health Services Sacramento, California

*State presentations were given twice.

TOPIC	SPEAKER/PANEL
	State Panel Cont'd.
SUR as a Management Tool	Herbert Alfasso Bureau of Medical Assistance Department of Social Services Albany, New York
	Linda Stella SUR Division Department of Public Welfare St. Paul, Minnesota
	Central Office Resource: Daniel Boyle, Corrective Action Project Office of State Operations Medicaid Bureau/HCFA DHEW, Washington, D.C.
MMIS - PSRO	David Farrell Assistant Executive Director New Mexico PSRO Albuquerque, New Mexico
	James Healy, Manager of Ambulatory Review New Mexico PSRO Albuquerque, New Mexico
PACE: Utah's Approach to Physician Utilization	Sharon Wasek Systems Coordinator Office of Health Care Financing Department of Social Services Salt Lake City, Utah
	James Cannon Assistant Executive Director Utah PSRO Salt Lake City, Utah
Data and Information Necessary for Management Control of Fraud, Abuse, and Waste	Bruce Ferguson, Chief Office of Budget Services Department of Health and Social Services Olympia, Washington
	John Kasonic, President Kasonic and Associates Seattle, Washington

TOPIC	SPEAKER/PANEL
	State Panel, Cont'd.
New York: Third Party Liability Recovery or How New York Recouped Millions of Dollars Last Year	Charles Christopher, Deputy Commissioner Management Information Systems New York Department of Social Services Albany, New York The repeat session by New York was given by: Lloyd Moses, Director NYS Medicaid Systems and MMIS New York Department of Social Services Albany, New York
Minnesota: SUR II: Simplified Reporting for Surveillance and Utilization	Robert Baird, Assistant Commissioner Income Maintenance Department of Public Welfare St. Paul, Minnesota Linda Stella Surveillance and Utilization Review Division Department of Public Health St. Paul, Minnesota
New Jersey: MERS: Medical Exception Reporting System. A system tool for detecting fraud and abuse	Joseph Piazza, Assistant Director Division of Medical Assistance and Health Services Trenton, New Jersey Robert Yoder, Director Health Systems Management Optimum Systems, Inc. Santa Clara, California
Lessons Learned From Our Activities in Project Integrity	Thomas Morris Inspector General DHEW, Washington, D. C.

TOPIC	SPEAKER/PANEL
MMIS - New Directions	Leonard Schaeffer Administrator Health Care Financing Administration DHEW, Washington, D. C.
An Administrative Approach to Utilization Review	Joseph Chiaramonte, M.D. Assistant to the Director Medical Assistance Program Nassau County, New York
Medicare/Medicaid Integration Projects Status and Systems Impact	Lawrence Levinson, Deputy Director Office of State Operations HCFA/DHEW, Washington, D. C.
Future Requirements	William Hickman, Director Division of Analysis and Evaluation, Medicaid Bureau HCFA/DHEW, Washington, D. C.
	Al Dobson, Director Division of Beneficiary Studies Office of Policy, Planning and Research, HCFA DHEW, Washington, D. C.
	Charles McDermott, Comptroller Oklahoma Department of Institutional and Rehabilitation Services Oklahoma City, Oklahoma
MMIS Benefits and Evaluation	Robert Nakamoto, Director Division of Information Systems Medicaid Bureau/HCFA DHEW, Washington, D. C.

Welcome

Richard Heim, Director
Medicaid Bureau, HCFA
Washington, D. C.

Since becoming the Medicaid Director in HEW, in June of last year, I've made a number of speeches around the country, and in almost all of them, I begin by telling the group how pleased I am to be there. I suspect that there is a certain note of insincerity about those words. This morning, however, I can tell you very candidly that, indeed, I am pleased to be here; and I am pleased for a number of reasons, most important of which I suspect is that New Mexico is my home -- my residence has been in Albuquerque for the past 30 years, and so I'm always glad to come back home.

I'm also pleased to welcome you to a State that has experienced a number of firsts. Some of the people on the Eastern Seaboard don't like to admit it but New Mexico was the site of the first European settlement in the continental United States. It is also the site of the first capital in the continental United States, and for those of you who are religious-minded, the first church in the United States. Although some people don't like to admit this, it was also the site of the first bar and the first brothel. And as many of you know, New Mexico was the site of the first nuclear explosion back in 1945, which brought us into our nuclear age. So, it's probably very appropriate that New Mexico was the first to be certified as a Medicaid Management Information System State.

New Mexico was the first, but, as of right now, we have 23 States with certified Medicaid Management Information Systems, at design, development and installation costs of some $35 million and an annualized operational cost of more than $100 million. By the end of this year, 1979, we expect the number of certified States to increase to 33. The important thing is the States certified will cover approximately 79% of the program dollars in Medicaid, and by the end of 1980, we expect to have more than 41 certified systems covering 95% of the program dollars.

I'm also pleased to be here because on Thursday, the Administrator of the Health Care Financing Administration, Leonard Schaeffer, my immediate boss in HEW, will be here, and will be making a major policy speech, announcing some new national directions for MMIS. Also on Thursday, the Inspector General of the Department of Health, Education and Welfare will be here to share with you how critically important he thinks MMIS is to serve as a tool in the eradication of fraud, abuse and waste in the Medicaid program.

Recently, at the Inspector General's recommendation, an inter-agency task force on Medicaid Management Information Systems was set up in HEW and I was appointed chairman of this task force. The purpose of the group, to describe it succinctly, is to take a good, hard, in-depth look at where we are now in MMIS. Our job is to take a look at what presently is, to come up with some recommendations of what should be, to line up some goals and objectives for what MMIS should be as a major tool for managing Medicaid, and then, lastly, and very importantly, to develop the action steps to get to where we want to be. Some of this will be discussed by Mr. Schaeffer on Thursday.

As chairman of this task force, I am very pleased to be here at this meeting, and I intend to spend the entire three days here listening to you, particularly the State people, as you share your experiences of what you have done to make MMIS a more effective tool in your State. I have long felt that the most effective technical assistance in Medicaid, and other State-Federal programs, is the assistance that one State can give another. I also feel very strongly that it's not only what you can give to one another, but what you can give to us in the Federal Government. In my role as chairman of this task force, I'm looking to you to give us some very needed technical assistance. So call it reverse technical assistance if you will.

It's not only what can be learned from you at this meeting, but I think we need to have an on-going form of communications, not only with this task force, but with the Medicaid Bureau. So one of the results of this meeting that we hope to achieve is to set up a small group that we're going to initially call, "The National Technical Advisory Group" -- a group of State people knowledgeable about MMIS to work with the task force and with the Office of State Operations of the Medicaid Bureau in making MMIS a more effective tool for all of us.

Tomorrow, after the regular program, we should like to invite as many of the State people as possible who will be interested to meet with us in a planning session to talk about setting up this National Technical Advisory Group. Some people have suggested that we drop the word "technical" and just call it a national advisory group, and then we could call it by the acronym "NAG", and that, perhaps, is appropriate, because that's exactly what we would expect you to do.

Lastly, I am pleased to be here in my capacity as the Director of Medicaid, a program that is presently serving some 23 million persons -- the children, the elderly, the poor and the sick in 53 jurisdictions -- 49 States, the District of Columbia and three territories.

I'm sure you have been reading and hearing, as I have, about everything that's wrong with Medicaid. There are a lot of things wrong with Medicaid; we've got a lot of problems in the administration of Medicaid, and I'm sure you are as aware, as I, of the mood of the country today, the mood of the American people, on how their tax monies are being spent.

I think we owe it to the people we serve; I think we owe it to the American taxpayers to manage our programs as efficiently, as economically, and as effectively as possible. I've long felt that the tool for improved management of this very important, but very difficult, very politically sensitive program is an efficient and effective and operational Medicaid Management Information System. Therefore, I look at this meeting with a great degree of anticipation and expectation to learn from you, how we can better use this tool to serve the poor, the elderly and the sick and the dependent citizens in such a way that the American taxpayer will not

object to the spending of their dollars for this program.

If, as an IBM saying goes, the future is a moving target, I think that MMIS is our weapon, and I look to this meeting and to subsequent meetings with State people to help all of us improve our aim.

Thank you very much. I really look forward to a very productive meeting.

Remarks

Larry Ingram, Secretary
Department of Human Resources
Sante Fe, N. M.

Welcome to the conference relating to Medicaid management. Dick's association with New Mexico goes back a good way, and we're very proud of the achievements that he left behind, and the legacy that he has shown us. In fact, in the office that I have, Dick, there's still a shelf or two of old reports and pieces of legislation with your name in them, and your notes and stars beside certain legislators, and question marks, and some of those other items.

Our legislature just started, and we have somewhat of a turmoil in the House side. The leadership changed after eight years to a new coalition group. I did notice in the paper this morning that "The House Ends Patronage Hiring," and right under that "Senate Bill Limits State Employment." I don't know where that's going to lead us or what we're going into, but it's going to be an interesting session this time, I think, in New Mexico.

The Governor does extend his welcome to you and we're sure that, because Dick is involved at the level he is, the location in Albuquerque didn't have anything to do with his participation. We were sure that it was done on an independent basis by staff members who realize the importance of being in a central area.

Looking at you, I'm reminded of the fellow who passed on and went up to the pearly gates and went to Saint Peter. They have a scoring system on making an entrance into the pearly gates; and he began enumerating his many achievements: Kiwanis Club Member -- 10 points; Boy Scout, Eagle Scout -- 5 points; 4-H Member -- 3 points. He kept enumerating all of his achievements and he came up little short. He got about 70 and that was about as far as he could go on a ranking of 100; and he began to sweat and bleed a little bit. St. Peter said, "Well now, what else have you done? Surely there must be something else." And he said, "Well, I just finished being a Medicaid fiscal manager out in New Mexico." And St. Peter said, "Well, come on in. You've suffered enough."

We are especially pleased here that you all have picked this area, because New Mexico was the first State in the nation to receive certification of its Medicaid Management Information System, which was developed, tested and implemented by the Dykewood Corporation, the State's previous Medicaid fiscal agent.

We also received certification of the Medicaid Management Information System installed by our current fiscal agent, the Electronic Data System Federal. I've had an opportunity to review the agenda, as you have, and I think you're going to have some interesting conversations and exchange of ideas in the next few days, and I hope that some of our people are able to interact with you.

In New Mexico, Medicaid is one of the largest expenditure programs administered by the Department of Human Services and one of the larger percentiles for the whole State budget. I'm sure that in other States,

Medicaid expenditures represent a substantial amount of the budget for human service programs. In the current year, our Medicaid program is adequately funded; however,I realize that the program will require aggressive monitoring and effective management in order to maintain future stability.

I might point out that because of the foresight of Richard, we're now in a position to effectively address many of the problems associated in managing the Medicaid program. I say this because it was during his term as executive director of the old program in the State, that the first system which we operated was certified as meeting the Medicaid Management Information criteria. We are pleased and privileged to have Dick return to New Mexico and hope that he will continue to visit us on many other occasions.

We've all observed the effects of the spiraling inflation, and we know that Medicaid expenditures will apparently continue to increase. Those of you that are involved with State legislatures know the pressures that are being placed upon us. They have a tendency to want to cut down, very early on, whenever they call for tax reductions and tax decreases and they begin looking at where they can slash, and they begin looking in the human service area. It usually ends up -- what do you do whenever you begin cutting back on your bucks? You're either going to have to increase efficiency and eliminate your waste, or you're going to have to start cutting back on services.

I think that we also see a trend towards a more conservative spending pattern by all elected officials around the nation, and this apparent conflict on the spiraling increase of Medicaid costs and the conservative trend demonstrates a need for us to maintain management systems, not only for the purpose of receiving additional Federal funds for the cost of claims processed, but also so that management can be provided the necessary information to adequately administer and control its Medicaid expenditures. And all of you here today are directly interested in Medicaid management or you wouldn't be here, and I hope there's much we can learn from one another.

Here in New Mexico, we'd like to think that we've developed a successful program and we're looking forward to learning more about the benefits to be derived from the Medicaid Management Information System. We know that your participation, whether it be on the Federal level or as a State representative, will be productive.

I hope some cross-fertilization of ideas can take place, the end result which will help all of us, and serve to contribute to this concept thoughout the nation. Although the problems involved in managing an effective Medicaid program are a real challenge, I feel real confidence that this conference will provide all of us with the information and insight that will be helpful. As a layman, and a former businessman, and a politician, I think we're going to have to be extremely conscious, in

the next four to five years, of where we're going with regard to our Medicaid and Medicare programs. I think we're going to have to be extremely conscious about the controlling of the costs. I've been very active with our health systems agency in New Mexico, and I'm afraid that if we don't watch ourself, we're going to be looking more and more towards socialized medicine from womb to tomb, and it's an area that a lot of us are not comfortable with. I think we're creating our own problem, and I think it behooves us to call on our colleagues in the medical field and constantly remind them of this fact that is galloping upon us.

I think we're faced with a real dichotomy -- you're looking at a somewhat conservative nation, or a trend towards a little more moderation than we've had in the past, and yet we're not able to control one of the higher costs of government. I think what it's going to force us to do is end up with total control and not just partial control, that we've seen, down through the years. We do welcome you.

MMIS - New Directions

Leonard D. Schaeffer
Administrator
Health Care Financing Administration
HEW, Washington, D. C.

I am now functioning as the Administrator of HCFA, and I'm glad to have an opportunity to talk to you. I'm familiar with some people in this end of government, but not with all of you. You may have read some of the things in the health press, particularly, about my background. I don't have a health profession background, and I have been introduced, courtesy of some of the gossip sheets in Washington, at least, as a Califano crony.

I met Joe Califano for the first time 11 months ago. At that time, I had a good job with a good salary and a good future. And now I'm Administrator of HCFA. So, as far as I'm concerned, Joe owes me, not vice versa. If you've gotten the point of view, it's a little bit inaccurate. I am not a lawyer, I'm proud to say, so you don't have to fear that either.

And, actually, my background, both at Arthur Anderson, and when I first joined State government, is in data processing and management systems.

I'm returning to the health care field, and I am very interested and excited about that because it's an opportunity, I think, to work for an idea, and work for people who need help, and to play a part in our society that gives one a sense of satisfaction that I think is greater than in some other endeavors I've been involved in. And I'm very happy to be back in this end of the business.

It also gives you a sense of frustration and a sense of exhaustion sometimes in terms of all the roadblocks that you seem to find in your way. But on a personal basis, I'm very happy to be back in the health care field.

I also am reminded that I now have the job, and am physically in the office of a guy named Bob Fulton who, at one time, was the Administrator of SRS. You may not be familiar with him. Something like six years ago, just about this time, I came to Washington and told him how screwed up the SRS was, why his disallowance didn't make any sense, and on behalf of the people and the Governor of Illinois, I was going to tear him to shreads.

Now, I have his job, and I have been waiting for the Illinois delegation to come in and read my speech to me.

Very briefly, in case you don't know what the Health Care Financing Administration is, it is really five programs. We're responsible for the Medicare program, for the Medicaid program. We're Standards and Certification, which is basically the group that establishes the conditions of participation for institutions in those two programs. We fund and are responsible for the PSRO program, and we have an organization called the OPI, the Office of Program Integrity. It does not do criminal work, but does all the other kinds of work. And they are very involved in, on a regional basis, much of the fraud and abuse work that, I think, you're familiar with.

From a statistical point of view, though, we're an enormous organization. We spend, in terms of benefits, $40 billion a year on Medicare and Medicaid. There are about 45 million people enrolled in those two programs. Those programs are growing, particularly the Medicare side of our business. The greying of America is basically the growing of the Medicare program. We spend, every work day, $200 million. I wish we knew where every penny of it went, but we are doing it.

We do this, however -- and this is the thing that brings me here today, in the sense of our responsibility -- with a total of 4,500 employees. We are involved in big business. We're not involved in big government. HCFA is about as small an organization as you can find with a major Federal responsibility. The reason that we're so small is we depend on our partners. In the Medicare program, that's carriers and intermediaries. In the PSRO program, it's the physicians in this country, and in the Medicaid program, it's the States.

If you take a look at the funding for administrative costs, you find the Federal government spends $100 million a year on this program. We give the States over $700 million a year for administrative costs, and we pay out in benefits about $11 billion.

So most of this program is a State-operated endeavor in terms of funding. And when people talk about big government -- and I'm sure you've heard it in your States -- and they talk about Federal government not doing its job, unfortunately, they are not talking about the Feds, they're talking about all of us, particularly in the Medicaid program.

From a functional point of view, what HCFA does is very simple. We write policy, we write the procedures, we determine what standards institutions and providers have to meet. We implement those programs through third parties. We support about 60,000 full-time equivalents in States, carriers and intermediaries, and then we monitor implementation.

I think the functions are pretty straightforward. The question is, what are we trying to achieve? I think that's similar to yours. We are attempting to fund a delivery of appropriate health care services to eligible individuals in a timely and cost-effective manner. A piece of cake, right? Easy, no problems.

We are faced, particularly in the Medicaid program, with trying to provide services to a group of people who are clearly in need of those services, but for whom our society has not come to any great consensus as to what our responsibility is.

We're trying to provide those services in an economic environment, the health care environment, where the traditional laws of supply and demand don't work, where the consumer doesn't control consumption, where no one is really spending their own money to purchase services, and where, basically, the physician controls utilization. Seventy percent of hospi-

tal cost is under the control of the physicians.

So I think we're faced with a difficult social problem, and we're faced with an extremely complex system in which we're trying to fund appropriate care. One of the things that strikes me whenever I have to testify on the Hill, or whenever I'm called to account for government's alleged failure to function as well as private industry, is that the problems that we're dealing with are a hell of a lot more complicated than most of the problems that are faced by private industry, and that our chances for success are probably much lower, given that complexity, than many other endeavors.

Unfortunately, however, we're dealing with public funds. Our accountability for those funds is paramount if we're going to continue to serve our clientele.

That accountability is really what I want to talk about today. It's my feeling, based on my experience in Washington of only about a year, that our programs, HCFA, but, particularly Medicaid, are at risk. They are seriously vulnerable to changes in the political winds. The reasons are pretty straightforward, and you're aware of them.

There's a general public perception that big government has failed. You see it reflected in all the polls, you see it reflected in your mail, I would think, and certainly in mine.

That's a function of two things: one, very unrealistic expectations, in the '60s and '70s when these programs were created, but also real failures. We have not been able to make it work as well as we said we would.

Second, there's also a public perception that government is bloated and mismanaged, that even if the problems are worth attacking, the management is so poor that it's the wrong vehicle to try to help people. You see that in the press all the time, fraud, abuse and waste. I was reading a magazine about a month ago, and there was an article on fraud, abuse, and waste, and they didn't even bother to justify or to describe the kind of waste in HEW. They just took it for granted: the most wasteful agency in the Federal government.

Well, when they're talking about HEW and Medicaid, they're talking about States. That's where the money is.

I think there's also, in the political climate right now, a very real and growing perception that this country doesn't have the kind of money it had to throw at these problems. Productivity in this country is almost flat, the increase in government revenues in the Federal sector and in most States is really a function of inflation. We're in an era of limits; we cannot tolerate the kind of massive increase in expenditures we had in earlier years in this program.

When you put those things together, I think what you come up with is a series of reasons that have resulted in the conservative trend that we're seeing in Washington and I assume you're seeing in your State capitals. There's a loss of faith in government's ability to solve problems. I think the people are unwilling to pay higher taxes, either because they feel they can't afford them, themselves, or because they feel they won't get a result for it. I think there's an unwillingness, even, on the part of many people, to maintain their current commitment to our programs. I think we've seen that in Proposition 13 and other things across the country.

What I come down to, then, is if we're going to continue to provide adequate services, or attempt to provide adequate services, to our recipients, we've got to do a couple of things. We've got to increase the efficiency of our programs. We've got to use every buck we have, because there aren't going to be many new bucks, to make sure that they're turned into service delivery. We've got to eliminate whatever fraud, abuse and waste -- I think it's mostly waste -- that actually occurs so we can make those dollars available for programs.

We've got to do that, though, not just to get the money focused, because I think everybody is trying to do that, and has been for awhile, but to restore public confidence in these programs. Without that confidence, they're going to wither, and when they do, it's going to be the recipients, the people who need help, who are going to suffer. I don't think that you would be in this business if you didn't have some concern for those people.

By changing how we operate, by improving our actual operations, the reality of our situation, we can both serve our recipients and change the public perception. The changes I'm talking about, I think, are not all that radical or dramatic. They are better management, efficiency, and going about doing our business in a responsible manner.

If we can improve management, I think it'll help us not only in the two places I've already mentioned, but in the third area, which I am particularly vulnerable to these days, responding to legislative requests.

I assume that, if not you, the people with whom you work, trot up to the State legislator, like I did in Illinois, on a fairly regular basis, and try to explain those headlines that appear at least twice a year in the biggest newspaper in the State about Medicaid mills and about all kinds of unattractive occurrences. If we can't improve our management practices, if we can't respond to those legislative demands, I think the programs will be severely curtailed.

We need the information that describes who we're serving, what services are being delivered to those people, and how much we're paying. We need to improve claims processing. We've got to have more timely payment, and more accurate payment. We need to be able to describe

patterns of utilization. We need to make sure that everything we're paying for is a covered service. We need to make sure that third party liability has been explored. We need to improve linkages with other programs to assist their efforts and our own. Allegedly, every State Medicaid program is plugged into a Section 17 unit where that unit exists.

We need to work cooperatively with PSROs, with the Medicare carriers and intermediaries, and with other States. I've been involved fairly recently in some of these residency disputes, duplication of services issues. All of those things, I think, are things that we're sensitive to, and that we're concerned about.

The question is, how to get it done, in an era where the limits in the program are translated into limits on your staff and on your resources. Given the volume of transactions in the program, I think there's only one answer, and that's the MMIS system, which is why I'm here today. It's the best tool we have for improving management, and, in many cases, it's the only way that we can do the things I mentioned earlier on.

Before we can use it as well as we'd like, though, I think we have to get away from the idea that MMIS is simply a claims processing system. What it is is a vehicle to obtain the information we need to manage the program. What I think we need in most States, as we certainly need in the Medicare program, is a management control system.

We've got to know what's happening this month so that we can take action to correct it next month; not historical statistics, not a method for getting the paper moved more rapidly, but a way of finding out what's going on, and a method for helping us make the thing work better, more efficiently, more effective, as soon as possible. We've got to look at the results that can be achieved through the information MMIS gives us, not simply a throughput.

There are a number of States, I think, that have done very well. We have some outstanding examples we try to cite whenever we can. In New York City, they've cut down the time for paying claims from 90 days to 10 days. In Georgia, they're using a tape-to-tape formatting, which allows the State to increase processing speed, reduce errors, and according to the folks in Georgia, to save over $5 1/2 million, which is almost two percent of their program costs. In Michigan, partial automation of a third party liability system has identified about 140,000 Medicaid beneficiaries who may also have third party coverage.

Those are all, as isolated activities, laudable, commendable, good work. But they tend to be isolated, they tend to be one area in one State, one kind of improvement. We don't have -- or haven't managed to achieve over time -- a model that allows us to say, this system, this combination of software and hardware enables us to manage the whole program, to do all the things we really want to do.

I think the reasons are historic, and there are a combination of State and Federal problems. From what I can see, as a former State employee battling the Feds, and now a Federal employee trying to explain away the past, the tendency on both parts has been, in the MMIS area, to be very process-oriented, very system-designed, system specificiation, data-processing-oriented, instead of management-oriented.

I can remember, when I was in Illinois, some of the original hoops that the guys there had to jump through. And it seemed to me the Feds were, and have been for quite a while, much more concerned with adherence to design specifications than to the impact, the results of implementing an MMIS system.

I think we've worried you to death reviewing your plans for what you're going to do, but really haven't looked at what you've accomplished in any kind of rigorous way. We have not established standards for performance in terms of impact on program. We've got some technical standards that are pretty good that have prevented anybody from moving beyond 1972 technology, we've got some ideas about claims processing. But I don't really think we've looked at outcome, at program performance.

We haven't encouraged greater solutions; we haven't encouraged the use of new technology or more sophisticated techniques, and we haven't really done the job of transferring knowledge and experience gained in one State to another State, although I would like to put in a plug for the Institute for Medicaid Management. From what I have seen and heard from people I've talked to in a variety of States, it's one of the things that we're doing that has been successful in that it has facilitated one State helping another State. And that seems to be the best way for this cross-fertilization. I want to talk about that later.

We need your help in transferring experiences rather than the Federal government trying to learn all there is to learn, and then shoot it out and tell States how to operate.

States and the Federal government have to reorient our efforts toward outcomes, toward results; get off process, get off data processing for its own sake, and look at the impact we can have on our programs.

Our certification reviews, for instance, have been devoted to assessing the capacity of the system to process claims and to generate the required reports; there is no test as to whether anybody is looking at the reports, no test of whether anybody has done anything with the reports.

After we certify, we walk away from a State's MMIS. We haven't attempted to judge, once a system is operational, whether the system has any impact on improved program performance. We haven't asked the kind of questions that I think are important. I think they're important to you: have we achieved more timely claims payment? Has that improved provider satisfaction? Has that resulted in increased participation? Have im-

proved beneficiary files reduced eligibility error rates? Has the additional information on other sources of insurance increased third party collections, or have we even gotten to the point -- as I'm told they have in Michigan -- where we don't even pay without first checking for the availability of private insurance?

We haven't asked, for instance, whether more children are being tracked through EPSDT programs. We haven't asked some of the questions that we ought to be asking about quality. We haven't asked if improved reimbursement systems are reducing the rate of inflation.

I think Medicare and Medicaid, by virtue of the way they reimburse, promote inflationary pressures. We haven't asked if duplicate payments and other erroneous payments are being eliminated or reduced. We haven't looked at whether increased numbers of actionable referrals are being made to investigative units. We haven't asked a whole series of questions that are the important questions. And I think we have to begin asking them. And that's why I'm here.

Beginning today, in terms of public discussion, we're going to begin to refocus our efforts in the MMIS field from the process orientation to outcome-oriented performance standards. Our success in establishing those standards, and in achieving them, will depend on State participation in developing the standards themselves.

I'm counting on you as individuals and this organization for that participation. And I'd like to take a series of steps aimed at getting the participation and your assistance.

As Dick Heim mentioned on Tuesday, we've asked you to establish a National Technical Advisory Group as the primary vehicle, your involvement in the process of setting standards and developing techniques for evaluating performance against those standards. I'm very glad to hear from Dick that you've already responded to that invitation and that a steering committee has been formed.

We are going to establish output-oriented program-related standards. We'll do that, though, only after consultation with the States and only prospectively. We will attempt to make sure there is lead time for implementation. Ninety percent matching funds will be available for any systems changes that are required to meet the standards. Standards, as they're developed, will be proposed to the States no more frequently than once a year. There will not be change orders coming down the road once a month.

We'll try, wherever possible, to be sensitive to the constraints imposed on you by your own budget process. One of the problems, of course, is the way the Federal fiscal year now works. It basically screws everybody up.

In addition to establishing outcome-oriented standards, we're going to change the way that we evaluate and certify MMIS systems. Our primary evaluation will not be the technical adherence to the existing system design, rather, it will be performance against outcome standards.

We'll permit, and, I hope, encourage, creative approaches in the use of advanced technology and new designs. We'll certify individual MMIS modules, provided they have measurable impact on outcomes. We've done that in New York City and in Texas, and we'll encourage the development of individual modules for things like EPSDT, and its hoped for successor, CHAP.

However, we will re-evaluate the case of those MMIS systems already up, and evaluate, in the case of the new ones, performance against standards on a regular and continuing basis. By re-evaluation, I mean recertification for 75 percent matching funds. We just can't afford to walk away from a system once it's been certified.

We'll periodically check a system's adherence to those standards and those standards may increase in the sense that we may be expecting better performance over time. We will be looking at them on a regular basis.

What does that mean in terms of your State? If you're MMIS currently, or once the standards are in place, and after you've had a chance to make what changes you feel are necessary to meet them, if you can perform up to the standards level, you'll continue to be certified and receive the 75 percent match.

If the system doesn't do what everybody said it would do -- and you must remember, I was consultant for Arthur Anderson for several years and I remember selling systems -- trust me, in three years, everything will be okay. Right? And in two and a half, the job's over and you go on to the next one.

If those systems don't measure up to standards, even if they're already certified, and even if the MMIS meets the technical standards, then the State will lose certification and will revert to eligibility for the standard administrative match of 50 percent.

Now, that's not going to happen tomorrow; it's not going to happen next month. But once we get the standards developed, that will be the leverage that we will apply in terms of achieving the goals that we've jointly set.

The importance of setting the goals jointly, though, is paramount to me. Medicaid is run by the States, obviously. My responsibility, and Dick's responsibility, though, is to the Congress. We've got $12 billion in this operation, and we're assuming that you are performing consistent with the policies set by Congress and by HCFA. Developing these standards, I hope, will be an appealing idea. It's not meant as threatening,

and it's not meant to be unilateral action.

We'll use the National Technical Advisory Group to help establish those standards. I can guarantee you that we will listen to them. We'll be looking for claims processing standards, and we'll also be looking for program impact standards.

We'll, again, try to develop jointly an evaluation methodology on what basis we will judge performance. And we'll also ask that group to try to help us on this interstate transfer business. I really believe that it's only by State-by-State cooperation that we can spread the good news.

We'll also look to some of the lessons that we've learned from contractors and from the Medicare program. We have a contractual relationship with carriers and intermediaries. As a result, we have a great deal of experience regarding contractor performance. I think we have a less complex world in the Medicare program. So much of it is not directly transferrable.

But the idea of contractor productivity and contractor performance is not a new one to the Medicare program, and is certainly not a new one to some of those contractors who can be very helpful to us.

We will depend on the ingenuity of the States and the vendors with whom you work; there are lots of good ideas, lots of smart people. We'll try to improve our monitoring so that we're sensitive not just to the aggregate statistics, but to problems that are unique to individual States, which is what Medicare attempts to do.

We'll also be taking a look at what's called beneficiary and provider services. What should we expect a State to do? And what should we expect to fund in terms of dealing with the recipient community and with the provider community?

In terms of our support of your efforts, we will be highlighting State achievements whenever we can. In Congressional hearings, we'll be pointing out the States that have done good jobs to the degree we're aware of them, in press releases, in statements by the Secretary. I don't know if many of you saw it, but the Secretary went to New York City to announce the certification of New York City's MMIS system, and was joined by the Governor and the Mayor there in terms of expressing his confidence in the system and in the approach New York City was taking. We would like to do similar things in other States where there are significant achievements.

As an off-the-record remark, I think both the elected officials who might be involved in this type of activity and the Secretary get a great deal of enjoyment out of announcing successful management initiatives.

We'll also be borrowing some of the techniques that were used in the

establishment of the Section 17 fraud and abuse units. That is, where we can, we will send letters from the Secretary or from me to governors of States where we can assist in getting support for MMIS or for fraud and abuse units or for modules that you'd like to add; where we can demonstrate that they're cost-effective investments, we'll attempt to support you in those efforts.

To make this thing work, obviously, we need your commitment to about three things. I assume that it's all there. If it's not, I hope it can be developed. One is a commitment to manage the programs. There isn't enough money, there isn't enough confidence from the public, and there isn't enough time, given the pressures on State legislatures and the Congress, to allow us to act as simple stewards of a program. We've got to run them efficiently and effectively.

That means we've got to take on the management role. We need your commitment, secondly, to be creative. These problems are incredibly complex. If they were easy, we would have solved them a long time ago.

We need your commitment to work with us, as individuals and as a group. I'm personally a very strong believer in strong interest groups, where they're responsible and where they speak for their membership. It's much easier for the Federal government to negotiate with a group that knows its business and represents its members than it is to try to negotiate with 50 States. I would, therefore, encourage you to build up this organization or similar organizations that can speak for you to us.

On our side, you'll just have to wait and see. The traditional attitude in the Civil Service to governors, to secretaries, and now, I understand, to administrators of the Health Care Financing Administration, is, "We've seen them come, we've seen them go, and they don't really make any difference."

You'll have to wait and see, as I know you will. All I can say is, as far as I'm concerned, there is no other way to deal with either Medicare or Medicaid than to have sophisticated, automated management control systems. They cannot be managed any other way. It's just that simple.

My faith in those systems, when intelligent human beings have designed and run them, is fairly high. Beyond that, I'm probably the only person with a job like the one I have now who knows anything about data processing. And I have done quite a bit of selling for this idea. So if you do wait and see, I think you will see support coming out of HEW.

I hope that today will be the beginning of a relationship that says we are all committed to those three things. I hope that I'll be seeing you again, whenever I can, and that you feel free to contact the people in the Medicaid Bureau and many of the people who are here from HCFA today for assistance.

I appreciate your taking this time to listen to me, and I know that some of the things I propose are going to cause some problems in the near future. If we work together, we can solve most of those problems, and in the long term, I think we'll make everybody's job a bit easier.

The thing that sticks in my mind about all of this is that if we fail, it'll be people who really need our help that will get hurt. If we succeed, we can do a hell of a lot for those folks. So it's incumbent on us -- I think it's imperative -- to be successful.

If you have any questions, I'll be glad to answer them.

Questions and Answers

MR. WONG: Derek Wong, from Idaho. The total expenditure of MMIS is almost 3 1/2 percent to 4 percent of the total Medicaid program in Idaho. This would not happen in a bigger State. I believe, in a very large State, percentage-wise, it could be only one-tenth of a percent. Whenever you make systems changes, regardless of whether it's a bigger State or small State, it requires the same cost. There's an old Chinese saying that, "Although a bird is small, it has all the essential organs; stomach, heart, everything, you name it -- essential organs. You have to have it."

Now, my question is, since we have a formula to calculate the Federal Medicaid assistance program percentage, can we do the same thing for the 75% match, like, maybe, for Idaho, you give 90 percent rather than 75 percent.

I think I have a lot of problems explaining to the legislature why we increased this much money last year to meet certain reporting standards. They don't look from the standpoint of program savings, they look from the standpoint of percentage-wise; how much you over-utilize.

MR. SCHAEFFER: I think the question is would it be possible to provide different matching rates for different size States? That does not have as much appeal as you might think when you're talking to the Federal Congress. It's not something I've really ever considered.

I think the other side of it, though, is much more realistic, which is the cost benefit associated with the burden that's placed on a given State, and perhaps, for some States, some of the reporting requirements may not be appropriate.

We're taking a look, for instance, in hospital cost containment, at the difference between the hospitals under 100 beds and hospitals over 100 beds. We've never looked at States that way, but we obviously could from a cost benefit point of view.

Personally -- and this is not very popular in Washington -- it seems to me that, operationally, all States are not alike, and we shouldn't necessarily treat them alike. The problem becomes -- when you try to make those differences and those differences are translated into funding -- you find out that every single State has two Senators, and each one wants the same amount for that State; that every single State does have representatives in the Congress and they are very reluctant to give more money, either in absolute dollars or on a percentage basis, to a given State.

But I think the way to go would be to take a look at the reporting requirements and what the cost benefit is. But, again, the cost benefit has got to be analyzed in terms of the program, not in terms of the computer capability. If it really costs a tremendous amount of money to do something in a given State, and it doesn't have the payback, then maybe we won't do it in that State.

I can't think of too many examples of that. I suppose it's possible, and we could take a look at it, but I wouldn't look for a higher match, as a short answer. I just don't see it. Take a look at your legislature and try to explain to them there are bigger and larger counties; "Could we give more money to one county and less money to another county?" That isn't going to fly. I think it's the other side we should take a look at.

MR. DAVIDSON: My name is Dave Davidson, from Alaska. I was going to chime in on Derek's comment. In smaller States -- and this has been especially true in Alaska in the year and a half that I've been there -- there is a lack of appreciation on the part of State legislatures, with the fact that each State in the Medicaid program has basic minimum requirements that they have to meet, and that, in order to fulfill those requirements, you have to have staff to do the work.

In Alaska, there has been difficulty in trying to convey that to the legislature in order to get enough funding, and, actually, enough interest, in the program to do some of the things that are needed to clean up the problems. And so I think, along that line, if there is some commitment on your part to assist smaller States with that particular problem, it would be appreciated.

MR. SCHAEFFER: Well, I think you're raising two kinds of problems which I didn't respond to in the first question. In terms of our ability to be of assistance, this corrective action program and some of the technical assistance ideas that we have would be available to States, large and small.

In some States that have mature systems and sophisticated systems, there really isn't that much that the Federal government can do. In fact, I assume we would be thrown out of Michigan for even attempting to offer advice. So, obviously, that kind of technical assistance would be more

available, or as available, to smaller States who would make more use of it.

In terms of support, with your legislature or with your governor, as I said, we have sent letters to governors regarding the Section 17 units, in fact, we have sent governors a letter saying, "You haven't applied, can we help you?",or saying, "You have applied. The application wasn't good enough. We'll come out and help you reapply"; or finally saying, "You applied, you got in, congratualtions. We'll come out and help you set up the unit."

We can apply that kind of support to the kind of requests that you have. I think, further, where you've got something that really has a cost-benefit association, we can draw public attention to it. And the Secretary has done that in some States.

MR. DAVIDSON: I know, particularly in Alaska, the comment that I've gotten in the past when talking to Federal people about coming in and actually assisting us with the legislature -- I guess you could call it lobbying, and there's been a real hesitancy, or at least there is some policy about not doing that. I feel if the program really is going to be a partnership, that the participation has to go all the way down the line.

MR. SCHAEFFER: Well, I think there's a very fine line there. We can offer expert testimony, we can help you prepare the documentation, we can do whatever is necessary to make the objective argument. Anything we can do to help you make your case, we will try to do.

MR. ALLEN: Paul Allen, from Michigan. I participated in the past two years in three seminars of the National Council of State Legislators in Seattle, in Boston, and in Denver. There were small States represented at every one of those, and Keith Weikel, at two of those three seminars, made the point very strongly with several hundred legislators that he felt there wasn't enough money being spent by the small States on this process. I think if you reinforce that, through the National Council of State Legislators, we might be able to make this point on a continuing basis.

MR. SCHAEFFER: The success of those kinds of efforts are based on your ability to impact programs. If what you want is a 168 versus a 158, or if what you want is more disc drives or an online system, that all sounds good to some of us as professionals in the field, but that really is meaningless to a State legislator. What they want is results; they want to see recoveries. They want to see cost go down or performance go up. They'd like to see more kids in the EPSDT program, if that's possible. They'd like to see those doctors off their backs, complaining about bills that are six months old.

If you can provide an impact on the quality of the program, I think you'll get support, and you may be able to get the legislature's support,

but it has to be real. It just doesn't fly to say the Federal government has come up with a six-volume set of standards, and in order to turn those standards into a system, I need $1.2 million -- which is what they've been costing on the average -- to do the programming for a Federally-designed book. It isn't going to fly. It's got to have some real impact.

MR. COX: I'm Wally Cox, with the Division for Medical Assistance in Kentucky. I think you've indicated that, in the future, there might be the possibility of certification of modules if they contribute to enhanced performance of the system. Could you be a little more specific on what a module might be? Is it a certain subset, so to speak, of the Blue Books, or might it be something innovative and new that would enhance the system?

MR. SCHAEFFER: I think it could be described as both. You could bring up part of the system and not all of it, and be able to demonstrate that it's cost effective as of the point in time you brought it up, and we could agree to certify that part of it at that time.

It also could involve more innovative ways of going about getting some of the results that we would like to get. With third party liability, there might be ways that we could trade information with insurance companies or with Medicare carriers and intermediaries.

There might be some opportunities for improving eligibility -- or reducing eligibility errors -- if we were able to do some work with the Welfare Department in your State.

My point, I think, is that a rigid insistence on implementing all of those books, for its own sake, is not terribly meaningful; that there are other ways of getting about accomplishing the goals of reducing costs consistent with high quality programs.

What we want is the good program and the low cost, not the book turned into software. I think that's the point. Also, given the long lead time with some of these things,we ought to be funding some of them a little bit earlier.

Lessons Learned from Our Activities in Project Integrity

Thomas Morris
Inspector General
HEW, Washington, D.C.

It's really a pleasure to come to meet with a group like this. I recall so well two years ago, in March of '77, a few of us, who were then not quite ready to go to work as the IG, went to Denver and met with a group very similar to this -- perhaps the same group -- and learned an awful lot during those three days.

At that meeting we had a dream which we talked to some of you about; we called it Project Integrity. And at that time we had no idea it would begin to roll as quickly as it did. But it was as early as a month later that Secretary Califano -- when we told him about that dream -- asked us to go to work full tilt. As many of you know, we did that and I want to report to you this morning on what happened as a result of that dream, as we see it from where I sit; what we've learned from it, where we hope to go in the future and some of the things that we won't do exactly the same way again.

Let me tell you about where Project Integrity stands today. As you will recall, we ran the claims paid in 1976 in 51 jurisdictions; 44 of those were complete runs and 7 were partial runs. Using screens, we identified about 47,000 providers, druggists and physicians. And we narrowed down, visually, to a group of about 2500. Our goal was to have 50 per State, deliberately, as a learning experience.

The audit agency then went to the hard-copy files and did a preliminary verification to separate out the obviously erroneous situations. We then began to assign those cases to interested investigative agencies. Most went to the States, but we kept some ourselves; some, as you know, are being worked on by postal inspection, FBI and others.

Now, where do we stand today? There are about 1200 active cases, divided roughly half and half between abuse and potential fraud. About two-thirds of the abuse cases are still undergoing action in the States; one-third of them have gone through final action, namely, overpayment recovery. Today the score stands at about $3.4 million in overpayments that the States are seeking to recover.

In addition, systems changes have been reported -- and I'm going to touch on a few of those in a minute -- that have recurring annual savings potentials on the order of $7 million. We think both of these numbers are quite partial at this point, and when the full program is run out they will be much greater.

On the criminal side, there have been so far 28 indictments of 37 individuals, but there are some 173 cases today in the hands of prosecuting authorities for decision. That's just a quick look back at where Project Integrity has been and has come to.

What about the future? As you know, we concluded that an effort of this scope is of great value as a learning experience, but is a poor technique as a steady diet. Its fallacy is it assumes each State has an

equal need, interest and capability to attack problems in a given health field, and, obviously, that's an incorrect assumption.

So, our plan today and for the future is to work with the States in a planning mode to select new subjects, to conduct research in the design and testing of detection techniques, especially those revolving around the computer, and then to make those techniques available on an optional basis to interested States.

Our hope is that for each new subject area there will be a few States across the country with a high interest and, thus, give us an opportunity to work together in a fruitful learning experience.

There are three such efforts underway today and, generally, we call them Project Integrity II. One is the analysis of billing practices of independent, commercial laboratories. In many cases, as you know, we are finding discriminatory billing of the Medicaid program and apparent collusion between labs and physicians.

This project is now active in seven States, and we expect three or four more to be joining in the next few months. The pilot work was done in the State of California, and I consider it some of the best work I've seen.

The second effort in Project Integrity II, similar to the first, is to expose abusive dental services. This has been designed by the Philadelphia Audit Office, working with both Virginia and the District of Columbia. Today that effort is underway in nine jurisdictions and, again, several others are giving it consideration.

The third effort has become known as Operation Crack Down, and is an organized approach on abuses of drugs, usually representing collusions between physicians, pharmacists and drug pushers. This matter, you know, became of high interest because of exposés in the Philadelphia area resulting from the clever work of a reporter who went undercover and posed as a drug pusher. As a result of his publicity, this matter has touched off a wave of Congressional interest, and just recently a GAO review was announced as a result of those exposés. To date there are some ten localities working together on this project.

I should point out that all of these are HCFA managed, that is, HCFA is actually overseeing the Federal participation in these three efforts, with support from our office. They expect next month, in late February, to have a "lessons learned" conference of the States in Operation Crack Down, and in the months of March and April, to do the same on both the labs and dentists.

We have about eight other projects in a research mode at this time. I'm not going to take time to go through them, but just to mention what's in the offing. We will be publishing technical details in the next 60 days.

There are a series of computer matching opportunities. One compares hospital inpatient and office visit billings for the same patient on the same date to expose duplicate charges. We've run tests of this in Connecticut, and are running them elsewhere, and this proves to be a useful thing to do.

Another is billing of physician procedure codes to expose excessive charges. I'm going to come back to that because it grew out of Project Integrity I.

A third is a billing of outpatient hospital services in search of duplicate or excessive charges. A fourth is a billing of medical supplies and equipment, including billing for services after death. Another is billing for transportation services, to expose unnecessary or excessive trips. And then finally, there is a project to screen a group of other medical practitioners, including podiatrists, ophthalmologists and chiropractors. Fourteen States thus far have cooperated in the pilot work which will lead to the computer techniques that we'll be publishing and make available to you.

Now, let me spend the rest of my time briefly summarizing what I think, are some of the key lessons learned from Project Integrity I. As most of you know by this time, we've been writing "lessons learned" memoranda for the last several months. The auditors, investigators and HCFA Program Integrity staff have been trying to synthesize what they feel has come out of this effort in each of the 51 jurisdictions. Thus far we've produced 50 drafts and the 51st is in the mail.

As I read through those documents -- and they've become a very valuable tome from my point of view -- and we hope to publish it and make it available to those interested, I tried to assess in each situation whether this was a worthwhile experience and to give it sort of a value, A, being outstanding; B, being satisfactory; C, being fair or poor.

I graded two out of three of the 51 jurisdictions' experiences as either A or B. The remaining one-third were fair or poor for a variety of reasons. One important one is because the State was way ahead of us and they did not learn much from that effort. Another was that the problems of the State were not very great in these areas and a third was the lack of interest which we encountered; that was the least important.

Let me give you a couple of quotes that come out of these "lessons learned" memoranda which illustrate some of the positive values. One of the States in the Northeast, according to the memorandum, which I'll quote, had the following to say: "Due to the cooperative attitudes shown by the State, an excellent working relationship with the HEW units involved has developed. That relationship can be expected to enhance future fraud and abuse control efforts."

In the Midwest the memorandum states, "The State feels that Project

Integrity has resulted in a more exacting case control system which should enhance their efforts in identifying fraud and abuse, and ensure a closer working relationship to its fiscal agents."

In the West one of the reports said that "Project Integrity I has resulted in improved channels of communication, strengthened our working relationships and instilled a deeper commitment toward the elimination of Medicaid fraud and abuse, both on the part of State personnel and those within the Federal government."

These quotes underscore what I feel to be a most important value of this particular effort, namely the increased understanding of the problems which each of us has, and an on-the-job training experience which I hope will make each of us more effective.

Now, let me turn for the moment to the specific lessons learned in the physician and drug area, and end up with one or two philosophic observations. On the physician's side, we analyzed the 51 jurisdiction reports to identify the most frequently recurring problems that have led either to administrative sanctions or to potential criminal cases. Most often mentioned is billing for the highest procedure code available: this, in fact, is mentioned in eight of the State reports.

The problem was particularly stressed by California, which indicated that it had 20 different RVS codes for office visits alone. Let me read you two which I think illustrate the nature of the problem.

The intermediate examination code is described as, "A complete history and physical examination of one or more organ systems, but not requiring a comprehensive evaluation of the patient as a whole."

The next higher ranking code is called the extended examination and its definition is, "One requiring an unusual amount of time, skill or judgment, but not necessitating a complete examination of the patient as a whole." If I were a doctor I don't think I would have much trouble selecting that higher code as the one to bill.

Second in frequency in this physician area is the ever present problem of duplicate billing problems. This resulted from a wide variety of problems cited by the memoranda, computer screenings being the most frequent, but the practice of allowing physicians to bill under more than one provider code was the problem in several States. Duplicate billings were found in 32 out of 50 physicians in Connecticut where we ran the inpatient hospital versus office visit billing match for the same day. That was nicknamed by our Under Secretary Champion as "Project Empty Bed" which we thought was pretty apropos. Another is just plainly the result of sloppy record-keeping; a source of duplicate billings occurred frequently in the case of partnerships or group practice.

In five States the evidence suggested that more than one member of a

partnership was billing for the patient's visit without apparent justification. Our imaginative auditor in that case described this as concurrent billing.

A third problem area closely allied to duplicate billing is the lack of precision in the claim or supporting records. It was surprising to me that we found this to be a problem across the county; it's not peculiar to any locality. Another aspect of this problem is the failure to show specific dates of service on the claim itself, or the failure to show all family member identifiers.

A fourth group of billing problems in the physician area is charging for full office visits when the services rendered did not require the presence of a physician, such as injections and blood tests. This was documented in at least five States. Closely related are billings for services not provided or not supervised by the billing physician.

Next we found a variety of abuses in the hospital area. One was billing for daily hospital visits whether such visits were performed or not. Another was billing for more than one service per visit, such as psychiatric service. A third was billing for after-surgery office visits when the fee for the surgery itself, presumably, covered after-care.

In the nursing home area we found the problem of multiple billings where the doctor sees a number of recipients per visit and charges the prime rate for each one when that is not permitted under State regulations.

Still another is the question of medical value of the necessity of the services rendered. In Washington, D. C., we found one physician who gave every patient an EKG on every visit. In another jurisdiction, there were several thousand cases of multiple visits billed at the prime rate when the rule in that State was that there should be one prime consultation at the prime rate and follow-up visits at a reduced rate.

Beyond the question of medical necessity is the unnecessary scope and duration of services. This was the cause of abuse in several States, in one of them the "lessons learned" memorandum says, "Out of 4,700 physicians in this Medicaid program, it appears that one out of six was providing more care to patients than is normally to be expected."

And, finally, there were a cluster of problems involving the laboratories and their relationships to the physician, and that did lead to Project Integrity II and the pilot work in California which I've already described.

Now, a variety of corrective actions are being applied to cope with these, according to the "lessons learned" reports. Perhaps the most frequently mentioned is better computer edits at the pre-payment stage,

supported by peer group comparisions. Another technique on which favorable experience was reported by many States is on-site review of physician records and interviewing of recipients.

I found it very interesting that while EOMBs are being widely used in compliance with HR-3 of last year, we found a great deal of skepticism regarding that technique as compared with the personal interview technique in identifying real problems. Perhaps there's something important here we ought to stop and think about.

Our auditors shared this skepticism, I might add, in a number of States, including here in New Mexico. A number of States are trying to solve the multiple procedure code problem and the multiple provider code problem. Laboratory problems are being attacked by paying laboratories directly; other abuses are being attacked by putting limitations on what will be reimbursed or how much, or how many visits, et cetera, will be reimbursed.

We do expect to publish these "lessons learned" memoranda for all 51 jurisdictions after the States themselves have had a chance to look at them and comment on them. And I suspect there will be a treasure of ideas for students like myself and you for some time to come.

Now, let me turn briefly to the drug lessons learned. I believe they were equally productive. The most frequently mentioned, as you would suspect is prescription splitting; 18 of the jurisdictions specifically reported this one and I suspect that many more had the same problem.

Rather than go through a catechism of the drug problems, let me quote from one "lessons learned" report. This happens to be the District of Columbia, where I believe every known drug problem has been encountered. I'm quoting just a few excerpts from that report: "One group of problems involves services billed but not rendered. This included duplicate billings; billings for the same drug and the code number of both generic and brand name; billing for greater quantities than ordered and dispensed; prescription splitting; billing for refills not authorized; billing for prescription drugs when over-the-counter items were prescribed and dispensed; billing for services for which there was no documentation; billing for greater drug strength than prescribed; use of outdated prescriptions by a provider; filling and refilling prescriptions without documented written or verbal orders; prescriptions from telephone orders which lacked vital information such as number, date, strength, dosage, et cetera, and, finally; charging the recipient as well as the program for the same service.

Many actions to cope with these problems are being taken with significant savings. One State in fact reports savings of $2 million from corrective actions in these areas.

One of the most frequent techniques is to institute a 30-day supply

equirement for maintenance type drugs, especially for nursing home ›atients, or to impose, in addition, strict authorization limits for refills of controlled drugs.

The telephone prescription abuse was a wide concern. Some States are now requiring signatures of both the doctor and the patient before honoring a claim; others require that the claim identify the prescribing physician who telephoned the prescription.

A combination prescription-invoice form is being used in Maryland and that intrigues me as one to look at. In fact, we found in Maryland, after looking at their worst cases in the drug area, that none met the test of either criminal or administrative sanctions.

Recipient interviews and on-site surveys of pharmacists was widely advocated and in-depth audits on a regular basis is now being practiced in a number of States.

What do we see ahead as a result of these kinds of lessons?

I'd like to sum up, referring to some of the correlations which sort of stand out as one studies this whole body of information, particularly in terms of comparing the successful results of Project Integrity with MMIS systems and their status, utilization review staffs, Section 17 units and the availability of adequate sanctions within the State.

Using the A and B States I referred to earlier, that is those that appeared to have a worthwhile experience out of this, most of the Section 17 units we found had been established in those particular States, those that had the A or B type experience, outstanding or satisfactory.

Secondly, the majority of the certified MMIS operations that expect to come on stream in the next year were in that category. Most of the successful utilization review staffs were in the A or B States. The States having a successful Project Integrity outcome also tended to have formal sanctions and active application techniques for those sanctions.

I might say that HCFA is very close now to issuing a regulation to mandate effective sanctions in all States which, I understand, has been widely requested of HCFA by the folks from the States. They are likewise perfecting a model Medicaid State law which will be offered for consideration.

We also found some negative correlations, and I'll end with two. In some States where there are now Section 17 units certified or planned, there appear to be opportunities to improve utilization review units, either in terms of size or quality. A similar negative correlation existed in some States having certified or planned MMIS systems.

Now I do not want to infer for a moment that we would discourage any

State from having an effective computer system or fraud investigation unit, but I do worry about the prospect of finding ourselves building such capabilities without filling that vital link needed to make effective use of the computer output in screening out the cases worthy of sanctions or fraud review. In other words, I believe, we need a balanced total system.

Now I would like to speculate, and get your views on the proposition that perhaps we ought to be thinking in terms of Federal incentives for the future to help States round out and balance out all components of a total system (the data base, the analytical effort of a UR system, as well as the skill of a well put together fraud control unit) so that we have a total ability to approach these problems and do not overdo one or the other.

I think what I've learned in the last two years is that we must work as partners in this effort, no one of us can mandate the other to do the job, we must learn how to do it together.

Let me challenge you again with that last thought of mine, which I haven't passed through my staff. Are we in danger of getting an imbalance in the resources that we put to work in the MMIS systems, the UR systems, and Section 17 systems, where the Federal incentives favor only one or two of those components at the expense perhaps of the third? This is what I'd like to get some reaction to. Is it a problem?

Questions and Answers

MR. DAVIDSON: My name is Dave Davidson. I'm from Alaska. We certainly have a unique problem with regard to implementing fraud and abuse simply because we have such a small staff. One of the problems that you just touched upon is the fact that there are financial incentives for fraud and abuse, but there are no financial incentives for a simple claims processing system that includes utilization and review without going into an MMIS system. We can't justify that kind of a system for our small State, but by the same token, we can't take advantage of the match for the fraud and abuse unit. I'd like to know what kind of recommendations you'd like if you're looking for specific recommendations from States?

MR. MORRIS: I am. One of our opportunities in the IG area is to make an annual report to the Congress and the Secretary, in which we can deal more broadly and more far ranging ways than the Department does in its normal legislative program. We are in search of ideas for future study by Congress and the Department to improve the statutes and the regulations.

MR. PIAZZA: Joe Piazza from New Jersey. We had a fraud control unit which predated Section 17 by about three years, and the Medicaid State agency had a staff which was in very nice balance with the fraud unit.

With the promulgation of Section 17 and the 90 percent Federal

matching dollars, the attorney general's Medicaid fraud unit has doubled. And quite frankly, the cases which they are to investigate now are twice as large as we are. So, I think there is an imbalance there. Perhaps some thought ought to be given to some increased matching for the State agency units which do the front end work.

Secondly, it seems that some State legislators have taken Section 17 to mean that they can terminate funding for the Medicaid agencies, and I think one State in point is Connecticut. Shortly after Section 17 was enacted, all funding in Connecticut for any abusive efforts was withdrawn. I think some thought must be given to that as well.

MR. CHIARAMONTE: My name is Joe Chiaramonte, I'm from Nassau County in New York.

I want to say that, in looking over the speakers, the only vendor of care that's going to address this conference is me. I'm an MD.

There are no people here from laboratories, from pharmacies. There seems to be no input from other than systems people to assist the States, the Federal government in arriving at what you describe is the totality of the issue.

I will make a point of this. I think abuse is the largest area in terms of dollars and in poor quality of medical care, which I have not heard addressed here and was infrequently addressed in December at Mr. Califano's conference.

MR. MORRIS: Joe, I've certainly got to agree with everything you've said. I think we do give insufficient attention to the provider and the practitioner, and to the quality aspect. Our own studies clearly show that fraud is, at best, 10 to 15 percent of the toal area of fraud, abuse and waste.

A Funny Thing Happened on the Way to Certification

John Hall, MMIS Project Director
Department of Social and Rehabilitation Services
Topeka, Kansas

You'll notice the program said, "A Funny Thing Happened to Me on the Way to Certification." I want to clear the air somewhat about this presentation. I'm going to have to read most of it, because there's no way you could memorize it.

I don't think that MMIS is particularly funny. I'll start from that premise. However, having lived with the Kansas project for 14 months, I found some ways of expressing what was transpiring that may have deviated from the norm maybe one, two, three or four standard deviations. It got to the place where they talked about a one-man operation; I think I typed 97 percent of the RFP that went out and all of the other materials -- I didn't have a secretary. It got to the place in time, and I don't want to steal anybody's thunder, or embarrass anybody, but I was writing memos to the Regional Office on the backs of paper towels that I got out of the men's room. I think the Federal representative from Region VII will attest to that. I told him if he didn't like that, he'd better watch it, because I'd go to that other paper that comes out of there and there'd be the long scroll coming to him next time.

After we went through the very exciting and exhilarating experience of trying to certify Kansas MMIS, I called the Federal staff aside one morning and I said, "Now here's really what happened. Here is the way it can be written in ways that you can understand."

We got the word back on August 8 that the Attorney General said that Kansas can no longer continue to go the fiscal agent route without putting it out for bid. And so, we had until July 1 to begin processing claims. And I heard it from Regional Office, I heard it from everybody that bid on MMIS in Kansas -- you don't know what you're in for. And every one of those admonitions turned out to be exactly 100 percent true.

You've got the Kansas MMIS and you start out with the initiation period, and you go clear to certification.

Then, I tried to figure out; where did we start, and how did we get there, and who got involved, because we had a bunch of people that I never knew existed. And when the guy said, "Ah - come over here and work on this MMIS, there's not much to it, you know, just a little information system, and you can do it in your spare time, and there's not a great deal of involvement." Then you'd be getting letters or telephone calls, "Well, now I'm from the Governor's Office. Now, I don't want to say now that the Governor is trying to put any pressure on you, but it would be wise if you did this-and-so." And so we had a lot of people getting involved.

Then we got down to the place that I think that we finally put it out for bid. Then we evaluated the bid -- we had an attempt to nullify the award. That's fun. Contract negotiation and approval.

Then we had the planning, development, implementation stages; the

operational phase of MMIS; and the certification review, the exit conference and we hope that within the next few weeks, we'll know whether we're certified or not.

Now, all of that's important and you must keep in mind all of those items, as I speak to you, because it will help you understand one man's, or one State's, MMIS. I tend, as I said, to be very serious about all matters -- you can't look at the funny side of anything.

You've seen the flow charts. And if I were to try to explain to you everything that transpired in those flow charts, it would take all day. So what I did was to write in 50 words or less, what was transpiring at all times.

I sat down one day and I said, "Somehow, for the historians of the State of Kansas, I must put in writing what transpired."

Let me read only one chapter of the book of MMIS. I will tell you now that, much to my surprise, I was awarded a book last Friday by sources to remain anonymous, that says, "Kansas MMIS as Viewed by John Hall", and it contains all of these and more of the types of things I'm about to relate to you, such as a Book 2 and Book 3 of MMIS.

And it came to pass in the city of Topekas that a decree was issued. In it, Attorney Generalus -- in the land of Social RehaSer, decreed "Thou House of Social RehaSer shall harken unto my words and have all the hosts of fiscal agentdom labor on the Titlus XIX --" (that's Roman for Medicaid Scrolls.) And that you shall no longer sing a cappella with the Blue Shield choir or play around the cross of the same color on thy sack bid and sultries."

So the elders of the House of Social RehaSer gathered together in the inner chambers of the holy place and spake on this manner. The Attorney Generalus, back from his sojourn and riding in an official Kanusius chariot, unofficially, must redeem himself and purge his transgressions. Therefore, the elders of the House of Social RehaSer knew that they must find a serf in the kingdom who could find favor in the eyes of the Attorney Generalus, and his utterances, written on scrolls, then could be the atonement for sin.

Then the elders of Social RehaSer spake on this wise. "Where can we find a vassal who knoweth little; but who will write on the parchments the things that would be pleasing to Attorney Generalus?" "Hark", cried the Chief of Administralia. "There abideth one in the land of Rehabilitatia that has been chasen three times by the Czar of all there are and VR, and this vassal can be bought for a pittance. Yea, he can even be had for nothing."

So it came to pass that the words of the Chief of Administralia were so. So the vassal of VR was brought before the triumvirate of judges of the House of Social RehaSer to see if he was fair and comely, and was not wanton in the areas that Social RehaSer desired. The Chiefs of Administralia, Datum Processus, and Titlus XIX asked many riddles regarding that Roman program, Titlus XIX.

Yet in all of this, the vassal opened not his mouth, nor railed against his accusers, seeing that he did not understand Roman. Then the decree went abroad that the vassal of VR should henceforth be known as the Scribe of Titlus XIX. Then a solemn assembly of the high priests and the elders laid their hands on the vassal and annointed him Scribe of Titlus XIX.

Now, not many days hence, the scribe began to write on tablets of clay, the deeds that Titlus XIX had done in the days of the Blue Cross captivity. This angered the Titlus XIX handmaidens, and the legions thereof; and the Scribe cried out -- I'm sorry -- fleeing then, to a city of refuge. (That means I got kicked out of my office.)

Fleeing from the city of refuge, the scribe encamped in the land of Publica Assistiancia for 60 days, until the Titlus XIX's threats had changed from those of scorn to exile. Then the scribe crieth out, "Oh, wretched man that I am, who shall spare me from the wrath to come?"

Behold, there cometh from the land of Datum Processus, State Purchasia, and all the houses of Kanusius, to comfort the Holy One of Titlus XIX.

The parchments, the tablets of clay, and the etchings in sand were all derided as being worthless as the dung heap. "Down with him, down with him", came the cry, "for he knoweth not the law and the covenant, as set down by our forefathers in the land of Kanusius," uttered these wise men.

Then came a voice as one crying in the wilderness; knowing not from whence it came, the scribe of Titlus XIX followed. The voice was that of Augustus Kennedius, the direct descendent of King Richard the Lionhearted, King of State Purchasia in the land of Kanusius.

Thence, the humble servant, the Scribe of Titlus XIX, began to scribble. Only this time, it was at the feet of the great teachers of all of the land of the Departments of Administralia. Day and night, these learned scholars instructed the scribe in all of the ways of rightness, and he followed their teachings verbatim.

Then in the 11th month, on the 4th day, at the 9th hour of the reign of King James of Georgia, the King of Purchasia said, "Well done, thou good and faithful servant. Present now the parchments and tablets of clay thou has prepared and I will etch them into pillars of stone and broad-

cast them throughout the land, so that the scourge is ended, and that MMIS is near, yea, even at the door." (That was the release of the RFP, of course.)

In the 11th month on the 22nd day of the 3rd year of the reign of King Robertus Bennett -- (that was our Governor) -- all of the great, the near-great and the ingrates gathered to dispute and discuss the MMIS.

Of those gathered there, three did not understand what the Kanusius nation wanted; one was not aware that MMIS existed; and one was there because he heard there was going to be a meeting.

Still at the pre-bid conference, they gathered profits, beat their chest, pulled their hair, put on sackcloth and sat on their ash heaps and cried out with a loud voice.

(Now, that's not made up because one fellow there at the pre-bid conference had one of those styrofoam cups, and he got mad, or upset, or something, and he put his ashes in there and this thing just went up in a pillar of smoke. We had to clear the room. As I said, everything in here actually happened. None of it's made up.)

Then the King of Purchasia spoke and said, "Ask about MMIS and it shall be given you; seek and ye shall find; knock and I'll have my captains place you outside the chamber door." At about the time of the Messiah's birth, it came to pass that the parchments of the wise men were gathered together into the House of State Purchasia, who was the direct descendent and possible heir to the throne of King Richard the Lion-hearted.

And Augustus Kennedius taketh the parchments, and ordained the Scribe of Titlus XIX to see that the words of the wise men were acceptable in his sight. (Of course, now this is the evaluation of the RFP; they're the bids that come back.)

On the parchment of one of the bids -- EDS Federalus -- the scribe wrote, "Well done, thou good and faithful servant." The blessing pronounced upon the wise men of EDS Federalus angered the army of the Blue Shieldom warriors, and they took up their crosses, blue now being a significant color, and laid siege on the camp of the Attorney Generalus.

They cried out with a loud voice, "Woe unto the scribe of Titlus XIX, for he hath perpetrated a grievous sin against all the remnants of the house of Blue Shieldom."

They uttered again to the Prince of Attorney Generalus that for a half-score and two years their domain was not approached, and now the enemy from the land of Perlosia was enslaving the land of Kanusias.

The Prince of Attorney Generalus spake thusly, "What is done is

done. The scribe of Titlus XIX hath followed my commandments and in all manner is pleasing in my sight." Then the King of Perlosia sent his emissaries to Kanusias to bring an end to the dominion of the house of Blue Shieldom, and Augustus Kennedius saith it is good, and washed his hands of the whole affair.

Now, if you were to pick that up as an outsider in Kansas, you wouldn't know a thing that was going on. I've worked around EDS for a while; they know what's going on, and everybody that's here from CSC and TCC and Blue Cross or any other place knows exactly what I'm talking about. It was a fun time.

You know, you just can't live in the past, you must go on and I won't read you any more books of MMIS. When you start to plan an MMIS, you begin to deal with a lot of people, and they all talk in acronyms.

You saw all of the little charts there; the Attorney General; you saw Public Assistance; you saw Medical Service; State Purchasing, and when you go down to meet with them, they all rattle out the alphabet to you. And so, I sat down one day, and tried to put it all back together, and here's what came out -- acronyms of MMIS.

One day while working in DVR I got a call from JCS in SRS and he said, "Come over to our side and work with MMIS." Now, I'd never heard of MMIS, but I figured it was more of a challenge than DVR. JCS explained that MMIS was an information system for MSS. He said that all you had to do was write an APD and RFP to HEW SRS for increased FFP.

Delighted at the opportunity, I embarked on the project of writing an APD and an RFP that took me through all of the realms of DOA, ANR, DP, FAA and the AG's office. In beginning to write the RFP, I was soon admonished by RO of HEW, that HEW SRS was no longer existent, but rather it was now affectionately known as HEW HCFA.

Seeing the error of my ways, I repeated 1,000 times, that never again would my lips stumble over such sacred terms as RFP, APD, MMIS, FFP, FAA, ANR, DOA, MSS, PA, MA, or any of the other terms held so dearly by bureaucrats at every level.

Then came the day in Kansas to hold the bidders conference, and the whole alphabet was there. There was PHA, CSC, PRC, BC/BS, TCC, MS, KPF, CIH&S, D&A, EDSF and HEW HCFA. The bids were closed and the successful bidder was announced, and you guessed it, another four-letter acronym -- EDSF.

When EDSF came to town, the MMIS fun was only to begin. There were meetings held in the a.m. and the p.m. to discuss all types of problems. With MMIS, FAA, DOA, RNS, and SRS, EDSF talked about ID's, FPP, SRO's, TPL's; sometime all in the same sentence.

Meetings were held to discuss the TADs and ICF/SNF and ICF/MRs. By this time my head was swirling, but I kept setting up meetings and attending them to see if anyone would run out of acronyms, or even duplicate some.

To my surprise, it never happened. Some education was accomplished when a few people discerned that MARS was not a chocolate and nut covered candy bar or the red planet. However, every accomplishment was tempered with a setback, when others believed SUR to be a gentleman incorrectly spelled.

Days passed, and then I heard about EPSDT. I thought this time I'd surely found the answer -- EPSDT had to be Hebrew. And all that I needed to do was to get the vowels inserted correctly and decipher the word; however, true to past form, I failed again.

Then EDS decided they would construct claim forms to comply with MMIS and put on them things like EKG, HIC and they didn't want to process it with OCR. MSS wanted CRTs to read all about the items on their RA but SRS did not see the need in buying those. The ADs and the RPHs jumped on their PDRs and said make sure you get PA for certain services.

Then there was the inclusion of the LOF on OP, IP, SNF, ICF/MR, IP signed off by the director of MSS, K, OK, RN.

In the conversation with PA, we learned all about the 310Ts and the 155s and the SB and how the IM workers carried out all of these tasks. Time and time again, we heard how BC and BS formerly handled their EDP. And just as many curses against EDSF because they were not going to retain the status quo.

RNS and FAA couldn't match their 2082s and OA-41s to send to HEW HCFA, so they pulled their collective hair.

ADC and AFC and GA are herein inserted with special note that they were never forgotten. Then after meetings with SRS, with EDSF, there came outside acronyms, such as the KPA, who wanted EDSF to support their DURS.

Also, such honored acronyms as KNHA, KHA, KCA, and other non-interest groups made their interest known. Then about the time that the SNF, the ICF and the ICF/MR triad became clear in my mind, the acronym changed to ACH. After the first pay cycle was made, only the suffix "E" prevented it from being called ACHE.

EDS then put in place the systems edits of ACHs, formerly SNF, ICF and ICF/MR; and to this day, I do not know how to pronounce DELDSTCCMSCOP-DIDE or MDE.

Of course, my favorite subject is TPL, because of the many acronyms

it generates. I could hardly keep from crying when I heard such acronyms as OHI, WC, RD, VA, MED ANB, DHM, and a cast of thousands. No one can ever write about MSS and its dealings without referring to that headline topic, FP, and its 90/10 FFP and its resultant FLAP. How eloquently the RPH spoke of the NDC and the FP, and how it must be captured in the MARS for the NCSS 2082 and other stirring and exciting reports.

The MD and the NMSS has his own terminology when he speaks of PSROs and the MOU, and down to the very end, I did not know what an MOU was. I finally had to ask him. I thought it was something that a cow did and it was incorrectly spelled.

EDSF adds little to my understanding, however, when they put out ICNs and PCNs on their claim forms, and then refer them back to their RAs. EDS began to swamp me later on in the project with MARS and SUR reports with such enlightening titles -- now, grasp these, HMMR 101H, HMMR 384H, written in JCLCOBOL. And I wonder -- would RMN have uttered such things into his now infamous Watergate tapes?

Now, 13 months have passed since the project began, and I have been told to get ready for certification by HEW HCFA, the successor to HEW SRS.

This means that the APD and the RFP as drawn up by SRS for MSS with the assistance of RNS, FAA, ANR, DOA and SPD, et al, will be submitted to HEW HCFA to see if we are in compliance with MSA, PRG-31. If compliance is met, then the MMIS or MSS, as designed by EDSF, will qualify for increased FFP. However, if this process fails, then as the PD of the MMIS, I will be SOL at the SOB and my new job will be with the TRD and here's the hint. Their motto is, quote, "Satisfaction guaranteed or double your trash back."

Now, that got people's attention. MMIS was still kind of galloping along at a snail's pace at that time, however. I knew it when the people at the highest echelons in certain areas would come up and say, "Now, if we're going to do anything with that MMIS, we ought to get with it." RFP had already been bid.

So I thought it was time to do an educational program, so I did one on one of the six subsystems. I thought the one that would get the most attention would be SUR, so here's the way that I tried to advertise SUR on our bulletin board.

Are you interested in an all expense-paid vacation? Would you like to spend time along the banks of the scenic Missouri River, with its rolling farmlands and fall foliage and fauna in brilliant colors, being as close as looking out your window? This can be yours, and even more, if you are the winner of the SRS Sweepstakes. Never again will you have to put up with a nagging spouse, crying child, or a leaky faucet. No more will you tire of mowing the lawn, raking the leaves, or shoveling snow.

The State of Kansas, through its duly authorized agencies, is prepared to give you all of these luxuries, and even more, such as: (1) private and semi-private rooms; (2) three square meals a day served family style; (3) supervised crafts; (4) recreational facilities; (5) free medical services; (6) chapel services for all faiths; and (7) free movies.

Now these and many more activities are yours for the asking. All that you have to do is register. The competition is open to anyone, whether rich or poor, doctor, lawyer or merchant chief. All that you have to do is get in touch with the local SRS office, conveniently located in all 105 counties of the State, and sign up for public assistance.

You must meet minimal poverty requirements to enter; if you do not meet the requirements, tell a little white lie, and get your name into the grand sweepstakes barrel. If you are a nursing home director, ambulance service, pharmacist, hospital administrator, chiropractor, dentist, quack, or anyone else who has taken the Hippocratic Oath, just write to Medical Services of SRS, in 25 words or less and tell why you would like to be considered for the expense-free vacation.

To be in the running, the public assistance recipient must do something similar but not limited to the following: (1) have seen more than 30 doctors in a 90-day period; (2) presented 30 or more prescriptions for 20 librium 10-milligram capsules in a 90-day period; (3) had 45 chiropractic treatments or more in a one-week period at the local massage parlor.

Note that judges do not want to stifle originality, therefore, the more original the recipient becomes, the longer his vacation will be.

To be in the running for the grand sweepstakes prize, the provider must have performed superhuman tasks, such as: (1) extracting the same tooth 16 times from a cadaver; (2) performing 6 abortions on a 96-year old man posthumously; or (3) performing three appendectomies while playing 18 holes of golf.

There will be winners in all classes and all prizes will be awarded and the decision of the judge, is final. In case of ties, both parties will receive the same prize.

All entries become the property of the SRS SUR unit and none will be returned. The firm of Hacker and Walker, are the keepers of the information and only they will have the winners hermetically sealed in plain red and white and blue envelopes.

The winners will be escorted, toll-free, across the Kansas Turnpike to the Bonner Springs exit. At that juncture, the convoy will proceed north to that quaint city by the river, Lansing, Kansas. A right turn midway through the city of Lansing will take the caravan to a rustic native stone structure. At this point, uniformed escorts will meet the entourage and they will be taken inside to meet the manager of the resort

facility, at which time they will be given their second prize -- a new suit of clothes.

The outfit of each winner is the same so that the recipient and provider will both look alike, and consequently, be treated with the same esteem during their vacation at the resort.

Many, many exciting experiences await the winner in the SRS Sweepstakes. So don't delay -- enter today.

Thank you for sitting through part of your coffee break, and for giving me the opportunity of sharing these things with you this morning.

The Need for Planning and Organizing for the Management of New Technology in a Public Agency

Bruce Kozlowski, Director MMIS
Analysis and Development Division
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Department of Social Services
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I don't know how anyone can follow Mr. Hall. I find myself in a position of speaking on a straight subject, having followed one of the world's greatest comedians. I'm not exactly sure how I got here, but I can give you a kind of short synopsis of the events and why I think they took place.

If you look at the title of this presentation, "The Need for Planning and Organizing for the Management of New Technology in a Public Agency", I'm sure you question, as much as I do, "What does that mean?"

And in order of things, I think that title was developed in our bureaucracy in Washington, and then I found out there had been several speakers who were assigned to speak on this matter and all backed out ahead of time, and they asked me to come. I came because they offered to pay my way here, and I had no other way to come.

Then I found out that the reason everybody else backed out was because the other speakers all knew about Mr. Hall. But that still leaves me the dilemma -- what is this subject all about? I envision the purpose of this presentation to provide a user's view of the challenges in administering a public program through utilization of new technologies.

To do this, I'm going to use a real-life example, one I'm very familiar with, and that's the Michigan Medical Assistance Program, which I've been with since inception and our takeover as the fiscal intermediaries for medical assistance.

We began back in 1966, like many other States, very small. We had 200,000 recipients; we expended $66 million. And our growth, like many other States, was rapid. We now service over 900,000 recipients and our expenditures for medical assistance alone are about $850 million.

One in ten of the citizens in the State of Michigan is on medical assistance. Our expenditures alone makes Michigan one of the biggest programs in the country; and from a fiscal standpoint, that's an honor we could do without.

From the very beginning, it was management's desire to maximize benefits, while minimizing administrative costs. We oftentimes lose sight of the fact that our whole purpose as intermediaries for this program is to insure maximum services to the medically and financially indigent in a given State.

As was the case in many States, the original program that was developed back in '66, was developed in a very short period of time. It failed to yield the kind of management controls and capabilities to provide for effective management of a public health program. We therefore initiated a project to design a new system that would give us capabilities for effective management.

This system was based on a degree of sophistication, automation, beyond that in existence at the time in health insurance programs. Intrinsic to this system was a data entry subsystem predicated on the use of optical scanning technology. This allowed us to make optimum use of rapid data entry techniques by literally reading typed invoices onto a tape, which could be easily assimilated into the system mainstream, bypassing the more expensive, time-consuming, conventional entry data techniques.

Because of the speed of this process, and the minimal front-end intervention, we were able to commence editing invoices through the invoice processing system within 24 to 48 hours from the time they were received from the post office.

Our experience to date has been that a complete cycle from receipt of an invoice to generation of a check, or the remittance advice, which is the accounting document, is 10 to 15 days for 85 percent of all the claims we receive, and 30 days or less for 99 percent. With a daily volume of over 70,000 claims per day, we're kind of proud of that experience.

I didn't come here to sell you on optical scanning, but I bring OCR up because we're one of the few States that uses it as an input mechanism. It was a very new technology when we introduced it back in 1972, especially for our kind of health application.

The introduction of optical scanning did not go easily. It was so new that we had to do a very extensive selling program, both our own internal management and with the providers of services, who were going to be impacted by this new monster called optical character reader.

Back in 1972, and even to the present, the general public has had a bad enough view of computers in general; here we were introducing something new, and we were doing it as a State entity taking over a health program. I need not tell you what the medical community and the general public thinks about bureaucrats getting involved in health care. But we did spend extensive hours introducing and training and familiarizing our own management with the ins and outs and what-fors of the thing called an optical character reader.

We also went out, at the same time, and, through work with our major provider associations, explained to them the working mechanism of optical scanning; the advantages that were going to be a result for them -- a shorter payment time than they've ever had before; and, very definitely, the advantages to the State, because we all pay taxes and the cost savings was going to be shared amongst all of us.

We ended up with a management group less leery about this new technological capability for data entry, and a provider community more willing to accept this new mode of processing and more apt to accept the kinds of problems that you experience when you debug the new system.

I think it was a good experience and in a policy we've followed since. If you're going to be effective, in any technological change, you have to have the support of your own internal management, their understanding, support and commitment, but at the same time, if it has a notable impact on the provider group, then it's to your advantage to include them very early on, and make them your friends in the endeavor rather than adversaries after the fact.

From an auditable cost standpoint, our OCR rental costs, manpower support, use of the specialized forms have proven to cost one-third to one-half of what the old key entry type system was running us. So, it was new technology; it's been very effective as far as processing; it's been very cost-effective to everyone, and, at the same time, we are able to implement it with all the problems that you have in implementing a new system, because we took the time and initiative to work with our own management and work with the outside provider groups.

This has not always proved to be that successful. I introduced, and worked with, the Canadian government on an optical scanning system for a bonding issue, and it proved beyond a doubt the importance of commitment to any technological change.

We went there, and a small contingent wanted to move forth with this new capability; overall management was adverse to it, they were very content with what they were doing. Cost wasn't that much of a consideration; the old system was working, let's not change it.

And we had a user group, which was the banks, and they were literally against any changes, because it would take a reorientation for them, and they were concerned about the problems that may result.

We were successful there in turning around the banks to be supportive of using this new system and that required forms, and the new format, appropriate typing, clear, concise, but we were never successful in convincing upper management of the advantages in using this equipment, and to commit themselves to using this equipment.

To this day, which is about five years after the fact, they operate with two systems in parallel; or, at least, if they're not using them in parallel, they're stand alone systems, side by side.

They will use scanning until there's a slight glitch in the system, and they immediately divert over to key-in coding, and they go along with that, while they fix the glitch. They're operating two systems, the duplication of which is unnecessary and the cost of which is never going to be justified. And they will never make the transition, because they lack commitment in their upper management to taking on this new system. You have to be totally committed; your people have to be involved.

We found an effective method to minimize manual input when we got to

optical scanning. At that point we moved to wanting to find a more effective method to bring about a reduction in the amount of paper flow that was going through our system. This is one time that we sought out the newest in technology and ended up to be 100 percent wrong.

In our system design, we failed to imagine that we were going to have as many pens as we did, and we designed our system to use the newest of reader-printers, to produce the hard copy necessary for claims resolution. Within a few short weeks, we found the machine couldn't produce enough copies to meet our needs and if we were to buy enough machines to come up with the copies, it was no longer cost-effective.

Because we operate in batch mode, a little hindsight paid off when we realized that by going to our original invoice batches, we could extract the hard copies we needed and satisfy our claim resolution requirements. This is one time where we didn't look at all the options, and we opted for sophistication that was beyond, first of all, its capability, and secondly, it proved to be beyond our needs.

So, I guess we need to temper what we do from a developmental standpoint; there's a lot of new things out there, but do we really need them?

We've gone on-line to enhance our claims resolution by using CRTs; that application has proved to be very effective, and a lot of States use it. It's an excellent vehicle for doing correction; you have an image, you bring the image up, you have quick transmission time, but, most of all, because you're on-line, it gives us the capability to access the system to meet a myriad of our management requirements.

We went into the use of tape-to-tape billing. That has been received with a minimum amount of emphasis from management. I'm not exactly sure why, we've been involved in doing so many other things in development of the program, tape-to-tape's been kind of left behind to fend for itself, but, we introduced it to our providers. It's been received fairly well, it sure as heck proves to be cost-effective to the standpoint that it bypasses our costs from optical scanning on the intitial input. The pen rate is substantially less than you have with any other mode of operation, because there's a pre-editing capability that can be built in.

The one thing we've been apprehensive about in tape-to tape is we have never developed it to the point, or defined it to the point, that it gives us the kind of management controls we feel comfortable with. Here's a vehicle I have no doubt could prove to be cost-effective. It is effective in getting the claims in; we have a large provider population that wants to use it, but we haven't maximized on its capabilities because of this apprehension.

We've undertaken, in the last couple of weeks, a new endeavor to reassess tape-to-tape, define its future from a management standpoint,

build it into one of our management goals, and with that kind of emphasis, I'm sure it's going to grow substantially.

Of the utmost importance -- and I think it's going to be the emphasis through this whole conference -- to the early success of our program, and to its present success, was the recognition of the newly developed Medicaid Management Information System as a means to improve the capability of the State to administer the Medicaid program.

Michigan obtained its certification for its system in 1976, and anybody who's gone through it knows that Mr. Hall's right in one respect -- a funny thing does happen on the way to certification. It's an interesting experience you never forget, and you swear it's never going to be over and when it comes, it's a refreshing feeling.

We were fortunate enough to have a tremendous amount of technical input and assistance which helped us get through the process that you have to go through for certification.

We continue to believe that MMIS is truly one of the greatest management concepts ever to come out of HEW. It has six main subsystems. For those of you who aren't certified, I want to tell you how we have used them for greater enhancement of our program.

There's the claim information system, provider enrollment, invoice processing -- which really has two subsystems: the claims processing subsystem and the reference file subsystem; surveillance and utilization review, which will be covered extensively over the next couple of days; and management and administrative reporting -- MARS -- which is an excellent management tool that I think is frequently ignored, is very seldom talked about at conferences, and hopefully, some day, it's going to come up as being one of the main topics.

The claim information system may be the neatest thing that's ever come down the pike for us. We put CIS in long before we were certified. The system gave us the capability to load recipient eligibility data on-line from all our counties to a central source. At the same time, it gave everyone the capability to access the central source for information, including our providers. Our major providers can request, and do use, CRTs for on-line access to recipient eligibility data.

This has done great things for our relationship to provider groups in participation, and has definitely cut down on the problems we had being inundated with telephone type access for client information.

Provider enrollment -- this is a system we put in at the time we got certified; we're in the process of rewriting it; it's been patched so many times we can't do anything with it anymore. We end up with a team of people that just were keeping it going. It's going to take us 18 months to rewrite it.

We're rewriting with the view that provider enrollment is more than just a single enrollment system; it should be a provider tool. We are redefining the data base; we're going to use provider enrollment as a reporting tool for provider activity for overall administration and, also, as another tool for indication of potential misutilization as a support for our SUR fraud and abuse efforts in Michigan.

Invoice processing system stands alone. We've been most satisfied with what we've been doing; we rewrote our system once, and that was after three years of operation. We're in the process of looking at rewriting it again.

MMIS is neat. The problem is Medicaid grows too fast. We put our system in effect, and pretty soon you find out your daily payroll is approaching to take longer than a data run. If you run five dailies and then you run a weekly, and your weekly payroll takes longer than a week, you really have problems. We approached that. We rewrote that so we now have a daily that runs less than a day, but our Region V office says that we should be able to run our whole daily in a couple of hours and, so, we're going to tap their great expertise to show us how that's done.

But volume increases have been substantial and at times we've planned for them and at times we didn't. When we talk about new technologies, we are talking about planning.

SUR, I'm going to just hit on briefly, because there is some definite discussion on it in great length. SUR is a neat concept. If you put it in full-blown, it's very expensive. You get all kinds of reports, reams and reams of reports, thousands and thousands of providers, all of whom are potentially abusing and misutilizing the system recipients.

Then you look to your fraud and abuse contingent and you say, "Okay, guys, we've given you 2,000 this quarter; go out and get them." They've only got forty people. The guy turns around and he says, "Well, that's really nice; I now have another 2,000; I've got file cabinets that have 8,000; I'm two and a half years behind in my investigations, and I don't need another quarterly run of reports."

So we started looking at SUR and saying, "This is nice, we're generating the data. Is it cost-effective? Is it efficient?" In our review, we were trying to find a better way to use SUR to meet our needs for fraud, abuse and for recipient overutilization, trying to find a way to minimize the reports that are being generated, but to maximize their use.

Being discussed here, is the new MERS system, in which I'm very interested. I've sat in many conferences in the last couple of years where people have talked about SUR and said, "Gee, it's a nice system,

but, we really aren't sure we're getting our best out of it." And maybe MERS is a modification or an answer to some of the apprehension.

We have, and are in the process of trying, a new thing called selective editing, which I won't elaborate on today. If you're interested, I will send you whatever material you want. Basically, what we're trying to do, in utilization of SUR, is identify providers so that we can review claims on a prepayment basis instead of pay and chase. Selective editing will give us the capability of being provider specific -- to change the fatal level for a given provider on an edit, to cause it to pan the world for everybody else; it may be an information-only type edit. It will give us the capability to have all his claims for a given procedure or a series of procedures to pend for manual review. So when you have a provider who is either violating a program you've identified administratively through one of your administrative controls -- a number of items a service is given in a period of time -- or is billing you for a whole set of lab services instead of the panel test that you're supposed to be paying for, you have an opportunity to have his claim come out on a prepayment basis for manual review. You can make a determination to either prove it or reject it. So we'll be doing these kind of determinations on a prepayment basis instead of a postpayment basis.

Providers who are identified will be tagged on the SUR and we'll use the SUR reports for the follow-up and back-up, and for subsequent referral.

We went through and we did a comprehensive study of our system back in 1976. We spent five months looking at the system, and came up with 73 recommendations. One of the recommendations was to go and change to a very sophisticated micrographic, high-reduction system, which was basically going to eliminate all paper. And it never got to that. You talk about new technologies in State government, or in any public agency, the one thing that's always forgotten is the 18 months or two years before you get an idea, you want something, and you're finally able to get it. The time frame ended up with our vendor withdrawing his offer, and our inability afterwards of buying what would have been a good system. We didn't plan; had we planned, we could have had it.

We did make 73 recommendations out of that system, most of which have been implemented to date, both from a manual and a systems end. We have procured some new equipment as a result of that, which has cut down our processing time and the amount of paperflow which, with the claim volume we have, is one of the most important things we can do. We spend a lot of time looking at new changes in the micrographic area, as a means of reducing the amount of paperflow and giving us an ability to process at a lower cost.

We are tied, like all other States, at a time now where money is at a premium. They talked about the Governor here talking about no new hiring. I don't think that's an exception; it's more often the rule right now in a

given State. You're required to put out better services and more services with less people, and at a lower cost. And if you do that, you have to remain as sophisticated as possible, and still be cost-effective.

We've long operated on a philosophy that the user must understand the system he uses, and be responsible for its development and subsequent enhancements. We're a very user-oriented system. Our managers are not systems-oriented, but understand the flow, interaction and complexities of the subsystems that make up MMIS.

To support this effort, the systems support staff is maintained to provide our management with the available options that will provide the data or system that is needed to justify the kinds of changes they want to make; provide the kind of guidance to give them the options that they want and need; and to provide data assistance, not just the shortest distance between two points.

Frequently, if the user doesn't have a lot of input, you go to systems and ask for a change, you get just that -- the shortest distance between two points, and not exactly what you wanted. So user input and user definition is of utmost requirement.

To further enhance this, we've introduced STM70, which is basically, structured systems design. We've found since the introduction that, because the user is required to sit down in great specificity and define his particular needs and the way his reports are to come out, what they're to say and the format, there has been a tremendous reduction in number of systems changes that are made immediately after implementation of a new program, new system or modification.

We have also introduced the requirement to management whereby a systems test is required before any new system or systems change is put into effect. The user provides the test data, the user reviews that test, and the user signs his name on the bottom of that test, certifying that it meets his requirements, wants and needs. This has also served to cut down, substantially, these post-implementation changes that so commonly exist and that are so very inefficient from a cost standpoint.

As I said before, we make tremendous use of our provider groups as far as a liaison activity, and explain to them what changes we're going to make both in system rewrites, introduction of new equipment. We talked about OCR earlier; we just changed our optical scanners to a new, more sophisticated system. We went back to our provider groups and told them why we were going to do it, because again, we're going to have some debugging problems. They've been supportive. The new system's going to give us the capability to not only read the data that comes in, but to microfilm it and put the claim reference number on it simultaneously, so we cut out two steps there. We cut out a number or people, and we come out with a lower cost overall. We use the provider groups as a lever to be able to make the kind of changes we need to be more effective

managers in the medical assistance program.

We introduced the use of the Honeywell page printer. It may not seem like much, except all the data reports that come out, including the ones to providers, are in a completely different format. They're more readable, but the report is smaller and has to be reformatted. Again, we introduced that to the provider groups, got a tremendous amount of support, and the transition went very, very well.

Whether you are a public agency or a private enterprise, demands upon us are exactly the same. Programs are growing in the numbers served and the costs for those services. Each day, there are more regulations to edit data to further ensure its validity. Each day, there are more regulations and ever-increasing demands to generate statistics of every category, in every format that's imaginable. The demand is there to do it, with no increase in administrative costs. That's a heck of a challenge.

To do this, you must have management oriented to seeking out and implementing new technologies that provide these cost-effective changes. The challenge is to attain the state-of-the-art in a cost-effective manner, to match the sophistication with your needs.

To accomplish this requires planning, so that the technical changes can be on-going, instead of the hop, skip and jump method we frequently use and operate under. As managers, we should be forever seeking to make the most efficient system; efficiency is what program management is all about.

Thank you very much.

The Role of Management Systems in Combating Fraud, Abuse, and Waste

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I'd first like to compliment Dick Heim and the Institute for Medicaid Management for the tone of this conference because, originally, I fought awfully hard not to be on this program. And that is because it seems to me that in most Federally-sponsored conferences, the Feds come down to tell all the State folks what new burden we've just laid on you, and to tell you our problems and not listen too much. It strikes me that I hope this is a permanent change of attitude in which the program is really one in which the State people are going to be able to tell us what they have learned and the kinds of experiences that they have, which we desperately need to know more about at the Federal level.

I think before I start, it might help if I just give you a brief outline of the Office of the Inspector General of HEW, because it's a relatively new institution. It started in April of 1977, and, we have two old parts of HEW that have been incorporated -- the HEW Audit Agency, which now has about 1,000 auditors; and the Office of Investigations, which will have about 200 investigators. They're strictly criminal investigators. Both of those offices, as a matter of their work, continue to show a number of individual flaws in HEW programs, and they go after a number of individual instances. So we thought it would be useful to organize a third branch of the Inspector General, a small staff, which would try to look at all these individual instances and see what's wrong with the program that allowed these kinds of things to happen in the first place. We call that Health Care and Systems Review, and this group is trying to look at a number of programs which have been most fraud prone. We've taken a look at the AFDC program; we've taken a brief look at at least the top ten States of Medicaid and we're taking a look now at the social services program.

And on Thursday, Tom Morris the Inspector General, will be here to tell you, in some detail, some of the things we've learned, particularly, through one of our matching programs called Project Integrity.

We've also, as part of our duties, done a number of computer matching programs. At the current time, we're running something we call Project Match, which takes the current AFDC rolls of all of the States, and matches them against the civilian and defense rosters. At this point, we expect that about $12 million of State and Federal matching funds will be saved just by matching Federal employment rolls against State welfare rolls, and the cost will be something about $1 million of Federal expense.

We've also done another computer matching program which is to take the total State AFDC rolls and match them against Social Security earnings records. We haven't yet projected how much that's going to save, but the City of New York tells us they expect, just as a result of that, to save about $9.6 million next year.

Based on the programs we've looked at so far, we, in the Inspector General's office, think there is probably a 90 percent correlation between

the amount of fraud and abuse in a State program and the quality of the State's management.

As a result, we're increasingly trying to focus our attention on problems of management within State programs. It needs to be said, of course, that in Medicaid a very high proportion of the problems that a State has in running its program are the responsibility of Congress and HEW regulations, but once that's said, there's still an awful lot of problems that are really State origin.

So we see our role, really, in Medicaid fraud and abuse, as mainly supporting activities to improve State management. If we don't get to that, we'll never get fraud and abuse stamped out of Medicaid.

It also needs to be said that, at the present time, and for the near future, the Congress and State legislators and the press are going to continue to focus on fraud. It sells papers; it gets votes, and it's important; it's important for the integrity of the program that we respond rapidly and well to any indication of fraud. I think it's for that reason that the Congress, in the last session, enacted the Medicare and Medicaid Anti-Fraud and Abuse Act. Section 17 of that Act provided increased Federal matching for the States that create fraud and abuse investigatory units.

There are a number of these units that are now operating, and effectively tracking down cases of fraud and abuse in your States. Unfortunately, a number of these units will never achieve full effectiveness, and the reason is, there are no adequate State records to begin with. A good fraud unit, essentially, is at the back end of a well-managed program. They're only as good as the leads they receive, and without the front end of a good program, which is an automated management information system, these fraud units can never function at maximum efficiency and effectiveness.

We believe because of the claims processing and surveillance and utilization review capabilities of MMIS, that the universal adoption of MMIS would be a very important step to Medicaid fraud and abuse control, and it's for this reason that we're so anxious to back Dick Heim in his efforts to get a lot more attention to the MMIS in the States.

Again, MMIS, in itself, will not control fraud and abuse. A State with a strong MMIS, but a weak, understaffed Section 17 fraud unit is probably not much better off in fraud control than one with neither. Most important, we believe that if all that a State has is a strong MMIS and a strong Section 17 fraud unit, they are probably no more than 50 percent of the way towards preventing, detecting, and prosecuting fraud and abuse.

The heart of a truly well-managed and effective program of fraud and abuse control is a surveilance and utilization control subsystem, adequately staffed by knowledgeable and energetic personnel. All of the effective

fraud and abuse programs that we're aware of have a core unit to perform identification of fraudulent or abusive utilization patterns. It's these unusual patterns of utilization which are a major indicator of fraud or abuse.

Examination of profiles of services provided to patients can be very revealing, as can examination of services provided to single recipients. A number of States have had a great deal of experience in this, and I don't think I need tell you about some of the individual practices. But I do think it's necessary to say that as in the case of claims processing, the key to detection of fraudulent or abusive utilization patterns is a sophisticated computer system which can analyze claims information to generate utilization pattern reports for classes of providers, individual providers, classes of recipients, and individual recipients. Thus, the surveillance and utilization review subsystem of MMIS is designed to provide the necessary profiles. You will be hearing a great deal more about this from States which have had operating experience with these SUR units, and we can only hope that a number of other States will be able to benefit from that kind of State experience. We know that States which have adopted the MMIS and a SUR subsystem have had to do an awful lot of fine tuning, because the systems' exceptions criteria frequently generate so many leads that available investigators cannot keep up with the workload. Other States which adopt these systems should also expect to go through a period of adjustment, during which the exceptions criteria are made realistic for the State in question.

Implementation of the MMIS-SUR component serves as the basis of an effective detection system, both for fraud and for abuse. Effective use of the SUR component, however, implies that adequate personnel are available to examine the exceptions reports and to determine which ones are candidates for detailed investigation.

I think that seems to be my main message, however simple-minded it is, and that is a number of States that we've looked at, which have good MMIS, just have not had the personnel to follow up and staff a SUR unit. And it strikes me that without that, you haven't got management, you haven't got control of that program. To whatever extent it's possible for the Inspector General of HEW to highlight that problem, particularly with your State legislators, we intend to do so.

The implementation of this system requires adequate personnel. There's no way around that. Without the adequate personnel to screen the exceptions reported and investigate cases that need it, the entire fraud control effort is likely to become bogged down in a sea of paper. Small staffs are unable to keep up with the volume of exceptions generated by MMIS. As Bruce has told you, that's been a problem in Michigan and a number of other States.

This problem should be diminished, however, as the SUR exceptions criteria become more sophisticated, and as staff sizes are increased in

reaction to the new MMIS fraud related workload.

It should be noted that there's a close relationship between the sophistication of its claims processing system, and the number of investigators required by a State. A manual system or an unsophisticated computerized claims processing system generally detects only a very limited number of suspected fraud cases. Most fraudulent claims are simply paid, therefore few investigators are needed to handle the cases detected.

As the sophistication of the claims processing system increases, up to a given level, the number of investigators needed greatly increases. The implementation of a moderately sophisticated computerized system, which generates many exceptions, will likely require a very large number of investigators to follow up the detected cases, even though an awful lot of these exceptions may turn out to be entirely legitimate. A large number of investigators is necessary because there's no way to identify the genuine instances of fraud or abuse without an investigation.

But as claims processing becomes more sophisticated, the requirements for investigations decrease. If the system is programmed to report only those few situations which are most likely to involve fraud or abuse, as indicated by the results of previous investigations, or through previous State experiences, then the fewer cases reported can be investigated by fewer investigators, who spend less time working on false leads. All very self-evident, but only in a few States are we aware of a very sophisticated set of screens which has had this success.

Regardless of the nature of the case detection system, at the first level of the investigative process, there must always be sufficient staff to review the detection information and make judgments as to the importance and priority of the various cases identified. This critical function, where it's performed at all, is usually conducted by the surveillance and utilization review unit, or a program abuse control unit.

We don't have any evidence to suggest that random complaints, hot lines, et cetera, serve as a very effective mechanism for detecting cases to be investigated. These sources can be valuable, but they're only a supplement to a strong detection system.

The strongest detection mechanism is the combination of a computerized claims processing system that provides various types of output reports with staffing levels sufficient for the program to be truly able to investigate detected cases, and review and supervise providers on a regular basis.

Lastly, we're much encouraged by meetings such as this. We think an awful lot of States have made far greater progress in fraud and abuse detection than the Federal government. I'm pleased that so many of these State programs will be described today. And we'd like to wish you continued success and offer the support of the Inspector General of HEW in highlighting problems with State legislatures, and with our own Congress.

An Administrative Approach to Utilization Review

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If I'm a little bit hesitant it's going to be because I don't want to duplicate what has already been said so eloquently by the speakers that preceded me. I will say that I am a practicing internist. I have affiliation with a PSRO. On the program you will see that I am listed as the Assistant to the Director of the Medicaid Program in Nassau County, in charge of the Division of Fraud and Abuse. But I do not come here in that auspices to address you.

I am past president of my peer review region, Region 15, Nassau County. I sit on the State Council of New York, on the Committee on Sanctions; if you talk about frustrations, there they are. I am also chairman of my utilization review committee at Mercy Hospital in Nassau County, it's a 400-bed hospital, and have had an opportunity to see and address those areas of fraud, abuse and waste.

Members of the Federal government and State government have addressed themselves to these areas. I see MMIS as really a tremendous force for the future.

All of us have had experience with computer readouts, data, and so forth, and they have been diverse, as has our region.

Region II, for example, stretches from Alaska to Puerto Rico. How do you program a computer to assess the delivery of medical care in those areas, right through that whole area? It's impossible.

If I, as a physician, can bring to the systems people a concept that we must address these issues on a regional, State level, and put it in at the front end of programming your computers, then only will we be able to come out with what Tom Morris and Mr. Schaeffer said: some decent outcome data that will help us formulate policy to improve the system and decrease the dollars spent.

I think what I'd like to do, in the short time that's left, is try to address the areas: fraud, error, abuse and waste. Waste being not measured only in dollars, but more importantly, measured in poor quality of medical care given to the recipients of the program.

I just want to touch momentarily, historically, on legislation. Title XVIII, Title XIX, and Title V, were designed to address, to provide medical care for those that were elderly, those that were chronically infirm, and for child abuse.

In your packets you will see a yellow sheet and there are black dots and black crosses. And if you'll look at that sheet, the black dots are what Title XIX mandated; the black crosses were those areas that the States could address under Title XIX which would be matched Federally.

Now, if you'll look down the States, you'll see that some have no optional Title XIX benefits, so they don't have the problems to address to Title XIX. I don't think that's right.

If you'll look at some of the other States that are causing part of the problem in our expenditures, New York, California, Illinois, you'll find that this is where the bulk of our monies are being spent, and fraud, abuse, error, are rampant.

In New York you'll find two blank areas; it used to be all black crosses right across, but they cut out chiropractor's services and podiatry. But the governor of our State at that time, when the law went into effect, seized upon this to grant everyone in our State every benefit that would take care of everything from clipping his toenails to cutting his hair, and everything in the middle. There was nothing that wasn't reimbursable. And the State government has finally found out that there are not enough dollars to pay for these services.

Therefore, it is on their request that systems people develop criteria, parameters, patterns, profiles that will enable competent professionals to interpret outcome data and develop policy, and reverse or modify legislation that is currently on the books, to make the program a success and address itself to all of the population of the United States.

I just want to share with you a couple of definitions of fraud -- what is fraud? In programming your machine on MMIS, it is relatively easy -- and I'm not a programmer -- but just philosophically I'm thinking, it's easy to take a form, and to see if there's double billing, billing for two practitioners at the same time, for the same disease or different diseases at the same time of day, if there is a surgical specialist treating tonsilitis and giving us a fee for service code of a surgical specialist.

The codes that were described earlier this morning imply time spent with patients; if you look at them it would take a 72-hour day to fulfill the fee for services that provider has billed the system for.

I don't want to confine my remarks only to physicians because it is rampant throughout the whole medical care delivery system -- pharmacies, labs, vendors of hearing aids, eyeglasses and on and on.

Error too, seems to be fairly easily identified. Is there a discrepancy between the amount billed for the service rendered? These areas, I think, can be addressed very, very quickly and appropriately.

The area of fraud, however, is the most costly of all. There is no advantage in recoupment; it is not cost-effective, but what it does is cut the cancers of those practitioners who do not give quality care for Federally and State funded dollars.

Abuse is the hardest to address. The abuse of the system, how is it abused, where is it abused; how can you systems people help us identify areas of abuse so that: (a) we can get recoupment for past dollars spent; and, (b) develop policy to prevent such practices in the future?

We heard a gentleman from New York speak about hard dollars that were saved once MMIS got into New York City and Bradford ran the program.

I beg to differ with him, I wish he were here in the audience so that he might rebut or question what I have to say. I don't deny that dollars have been saved, but those dollars have been saved by preventing erroneously prepared claim forms, and in a few instances, fraud, rather than abuse. So, there are monies saved. There are millions saved, but one would expect that from a properly programmed system.

But, again, now I will address abuse, as opposed to fraud and error. I think I'll do that by just giving some illustrations of practitioners and how they do abuse the system, and leave it to you to think about methods by which you can program your machines to help the interested professionals, the utilization people, to take administrative steps, rather than costly legal steps, and take policy steps to eliminate abuse from the system.

We keep on beating our breasts about Medicaid, Title XIX, and the abuse on that side. Medicaid is nothing more than the tail on the Medicare dog.

As I said in the beginning, Medicaid gave us certain mandated areas; the States had a chance to enlarge upon those, but they didn't do what I'm asking you to think about doing, develop programs that would identify areas of abuse to that system.

So, what happens when you get a computer run on a provider or a recipient, and you can go either way: PACE goes on the recipient end; other people go on the provider end. What you want to look for and be able to look for is when the patient was there, what he was treated for, was there appropriate medicine prescribed, were appropriate consultations asked for, was there appropriate laboratory work done?

The only way you can do that is at the computer end, look at the printout, but you must go back to the back end to look at the records, the claims forms and the doctor's records for the documentation of those services rendered. So that unless we have, from the computer people, patterns and profiles, we can't go back and look at the records.

In Nassau County we do have a computer system. It is, admittedly, not as sophisticated as a MMIS system can be, and will be, but, as poor as it is, from the end of 1976 to now there have been some 14 million hard dollars saved, recouped.

Another issue that wasn't addressed here is how about these practitioners that don't give quality care, what happens to them? Are they eliminated from the program? What happens, in most instances is that they are brought in, they're given a slap on the wrist and they go about their business.

In Nassau County, in that time frame that I referred to, we have had approximately 20 administrative hearings on providers about billing. All of those 20 providers either restored monies that were not properly paid for, for services that were not rendered, and 11 of them voluntarily withdrew from the Title XIX program for fear that if it went any further on appeal, they would lose their Title XVIII privileges, and further, their licensure would be questioned.

So, Title XIX, at least in our area of the country, is doing its job. There's no follow up. And this is where you people are going to have to help us.

I mentioned two things, patterns and profiles. The individual is not easy to identify, difficult to nail on one test, one visit; it's not cost-effective. But you look at him, either the recipient or the provider, and you develop a pattern. It is miraculous to see a repetition of patterns that should not be reimbursed, and, again, I will say, medically are inappropriate and not of quality.

So that when the Congress passed Title XIX, they wanted to eliminate a second class of citizens. What, indeed, has happened is we have fostered a second class of citizen under the Title XIX end of it, with poor reimbursement for the vendor and poor services for the recipient, in terms of quality of care.

We had one physician who was earning about $120,000 a year on Medicaid. Now, just imagine $120,000 on Medicaid alone.

Looking at the profiles that we got, our computer system was not sophisticated enough to tell us what the problem was, but it was more sophisticated when we went back to the batches and looked at our billing forms, that on Title XIX, Medicaid, we had a diagnosis, we had a procedure code and we had a fee. And we were billed either the deductible or the co-insurance. Now, we went back and got the EOBs, the explanation of benefits on the Title XVIII side. And what we came up with was astounding; there's no diagnosis on an EOB for Title XVIII. So how in the world can you match up, unless you have a diagnosis, the justification of the service, the prescription of the medication, the laboratory data -- that's only the beginning.

We looked at codes. For Greater New York Blue Cross, which is the major Title XVIII payor, one code alone covers 13 different procedures. So, you have a diabetic, which we could identify on the Title XIX side; he went to see the doctor for diabetes, but he received a code of 80-31.

And you look in the manual and it had everything from chloresterol, triglycerides, urine analyses, name it; so there was no way.

I wish there was somebody in the audience that would address this: are we locked in to paying for those services that Title XVIII has okayed? Is Title XIX locked in to paying? We have been, because nobody has been able to tell us otherwise.

One day we got a dump on the guy that was earning $120,000 a year. On that particular day he visited some hundred patients in one area of town, and all had the same diagnosis, CHF, congestive heart failure. The claim was clean, had his code number, had a diagnosis, had a proper cost, went right through the machine. And the way he was identified was because he was a high provider.

We went back to his records, looked at it and found no evidence that these patients were being treated for congestive heart failure. Further, the investigative team went to the locale where he was practicing -- it's a ghetto, an area where people live in adult homes, hotels -- and he made regular rounds, and an announcement was made to these mostly senile people, "The doctor is coming, line up."

So when we walked in we saw the line. There was a room where the doctor was, and there was a nurse outside the room that took blood pressure. We walked into the room and lo, and behold, there was no examining table, there was a chair, a round table and he was examining somebody with a stethoscope, with the patient fully clothed, and this is what we were being billed for, by this practitioner.

What do we do? We said, "Well, maybe we're wrong, let's ask him to come in and bring some of his records. And let's have an administrative hearing. Let's give him a chance to describe what his practice is."

And so he came, and he came with his lawyer. So, we got our lawyer -- you always have to have a lawyer with a lawyer. In just a few hours this individual asked to be relieved of any Title XIX patients.

I heard today, too, one of MMIS' claims to fame is the ability to turn around a billing in 10 days. I ask you to think about it for a minute, is that really what you want to do as a parameter of measurement for an effective system? Is it not more effective, in developing those profiles and patterns, to hold those claim forms where there is question as to fraud -- I'll leave error out because I'll say that we've already taken care of that -- and abuse until your professionals can look at the medical record (which is the patient's property, not the property of the physician, the State or the Federal government)? The privilege that the payors, the insurance companies have, is to go in and look at those documents.

If you look at the contracts on Medicare and Medicaid, there's a

disclaimer on every one of them, and on Blue Cross and Blue Shield that says, "I hereby give release to the payor of this claim to examine my records for propriety," and so that's where we have to go. That's where you people have to help us, and this is where we should work in the partnership that was alluded to by Mr. Morris and by Mr. Schaeffer. It has to be a partnership.

Wherever there's a practitioner that is not giving quality care -- is fraudulent and is producing waste -- it is axiomatic that around him those people that he refers to, those laboratories that he uses, those pharmacies that he uses, are in collaboration, and those patterns have to be considered when you develop your matrix.

Your matrix must mesh between the primary provider, and it should be cross-indexed so you can look at a provider by a laboratory; you can look at a laboratory by a pharmacy, and I'm sure the expertise in this room can develop that.

What I ask is that you get input at the front end by those health care professionals that are able to recognize abusive practice, fraudulent practice, and waste. You produce those programs that will identify these patterns and aberrant profiles, so that those competent professionals will be able to examine them, make decisions as to their propriety and then make recommendations which will result in one, recoupment and two, policy which will prevent further waste.

I could go on. I have many, many more examples. There is enough on the books now, in the way of legislation, policy, to enable the Federal Government, and more important, the States to examine these people while MMIS is being developed.

We heard a gentleman from Nebraska tell us it took six years for their MMIS to get operational. We heard someone from New York say that, even though they can't predict when MMIS is going to become effective in identifying these areas, they are going to take it over and eliminate the regions. That is not your problem. That is the problem of the legislators; it's a problem of Mr. Schaeffer; it's a problem of the people in HCFA.

We honest professionals make up the bulk of the vendors of medical care. How I hate to be addressed as a vendor, not that I think any less of the guy with the pushcart and the oranges, he's a vendor too, but we're doing different things.

I'm not going to go any further. I'm satisfied with what my frustrations are and with the direction that perhaps you might want to go. These are the people in the public sector, that run smart programs; there are PSROs that are doing their job; there are private corporations that can contract for this type of examination.

Thank you very much.

Medicare/Medicaid Integration Projects
Status and Systems Impact

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When HCFA was created, one of the purposes was to see whether we could start putting Medicare and Medicaid together, not necessarily the programs together, but the administration. Are there areas of commonality where it makes sense to have the programs operating the same way? After all, the basic purpose of the programs, financing medical care, although for different groups of people, is a very similar one.

A work group was set up last year. It identified 40 areas for potential integration. Of those, 20 were selected, and I'm going to talk to you today about that first group of 20.

What I'd like to do, very briefly, is tell you how we work. We're working on a project management basis. Each of the issues has a project team headed by a professional either in Medicare, Medicaid, or the Health Standards and Quality Bureau. Working with each of those teams is what I call a shadow team from the American Public Welfare Association, representing the State Medicaid directors, so that the teams are working closely with representatives of the Medicaid program.

I must say in all honesty that some teams are working better with some of their Medicaid counterparts than others for various reasons. But we believe very strongly that we're not going to just come out and, by ourselves, tell the Medicare contractors and the Medicaid States what is going to happen. What we're going to do is work with you to achieve consensus, and I think in many areas we are achieving consensus.

For the most part there isn't a lot of disagreement on our goals as far as what the projects want to do. The differences that we've had so far are related more to how we do them. There are a couple of the projects, though, that there's a good deal of disagreement as far as whether we should be doing them at all and we'll talk about that.

I will try to concentrate on the ones related to the systems area and just go very briefly over the other ones. I've grouped them into several different categories. The first group relates to reimbursement in the related projects.

The first one relates to common audit of hospitals. Right now there are about 37 States that use common audit, that means Medicaid/Medicare share the audit. Generally, Medicare does the audit; Medicaid uses it. We'd like to do something about getting all of the States into this.

Simply, what we've done is we have a memorandum of understanding that's been agreed to but not yet signed between the two bureaus saying that, when it's signed henceforth and forever, since Medicaid is entitled to the information anyway through freedom of information, it's wrong for us to ask for cost sharing. So we're going to stop asking for cost sharing, and we're going to let you have what you're entitled to.

We're also going to say that, if there are additional pieces of an audit that you want to do, you can go ahead and do them, over and above

what Medicare does, and that'll be reimbursed separately at the regular administrative cost basis. I don't think, however, that we will reimburse you for the same audit that Medicare has already performed if it really meets your purposes.

We have a project on uniform cost reporting and accounting system. This is one of those that everybody doesn't quite agree with. It's called SHUR. You've probably heard of it. The notice of proposed rule making was published on Tuesday. Probably 3,000 copies of the package have already been sent out to people who have asked for them. Anybody who's interested in it can write in and get a copy of it. We have a period for comments.

This is a very important piece. This will allow us to have the same kind of cost reporting system in Medicaid/Medicare; it'll allow us to better compare costs by institutions, and it will allow us to limit institutions' ability to maximize costs between the two programs. As you well know, providers have some very clever accountants, and they do some legal things to us right now that are costing us more money than we think they should. So we're working towards eliminating those loopholes.

We have another project on a common overpayment recovery monitoring system. This is something that's going to be affecting you. In Medicare we know what providers have overpayments. Now, basically, we're talking about institutional providers, but it's going to be extended eventually to non-institutional providers, too. We know in Medicare who owes us what and why. HCFA doesn't know that on the Medicaid side. Some States know that. Some States don't have as good accounting systems as they should either, as far as monitoring overpayments.

What we'd like to have is a system that will allow us to combine Medicare's overpayment monitoring system with Medicaid's, so we can make comparisons and see if this hospital owes Medicare money, does it owe Medicaid money? Does it owe it for the same reasons? When you get into common cost reporting, you get into common audit. Then it only makes sense that you have a common recovery system or at least, common monitoring system to know what's happening with overpayments.

This is at the stage now where the project manager in Medicare has prepared a proposal, given it to the Medicaid bureau, which did not agree with the proposal and has suggested some alternatives, most of which are unprintable, but we're going to work with it anyway.

I think Medicaid's point, and it's a good one, is that it's going to require a lot of bookkeeping, and the question is, "Is it necessary for us at the Federal level to have all of this information?" Perhaps it's only necessary for the States to have it in a certain format that then they could just provide it to us on an as-needed basis. This, at least, is their position and we will be discussing it with them further and we'll try to reach a compromise.

The next group of projects relate to claims processing, and there're seven of these. The first one relates to common provider identification numbers. And this is one where we now have a draft paper; it's been circulated through HCFA; it's been given to the APWA. They have a steering committee, headed by Tom Russo, State Director of New Jersey, and we're giving him all of the information. I think for something like this where we've got a document he will probably use a different approach as far as getting comments from the States; he'll deal with selected people as far as getting their comments.

I want to emphasize that for the most part we're talking now of first drafts, early pieces. We're not talking about going through the regular prior consultation process through Medicare, which will have to be done, and we're not talking about getting the normal comments that we would get through Medicaid, which will be done. We're talking about getting enough information that we can make what we think is a reasonable decision based on reasonable input, and then when we think we know what we want to do, at that point, we'll go out to the regular process to get comments.

There will be a common provider ID number -- the paper suggests this -- for institutional providers. The six digit certification number now used by Medicare and a number of Medicaid States, will be used for hospitals, SNFs, ICFs, Christian Science Sanitaria, all of the ones that are now covered in that process.

For non-institutional providers, it suggests that we use Social Security number and/or EIN, depending on whether or not we're dealing with an individual practitioner or whether we're dealing with a group. There are problems that we're facing right now using SSNs in a group setting, especially with physicians who are in a group and also have an individual practice. We're looking to see how we can deal with that.

How would we implement this? We understand, first of all, that we're not going to be implementing everything tomorrow. We're not going to be coming down and saying, "Okay, this is what it is and two months from now you've got to have it."

For those States that have fiscal agents, we will, and this is what the paper suggests, probably let you wait until the end of that contract, and then when you renew the contract, depending on the time frames again, at that point put this in as a requirement for your fiscal agent.

Now, in those cases where you've got contracts that are running several years, three or four years, and that are just beginning, I'm not sure that we can buy off on that, but there will be ample time for implementing this.

As far as costs are concerned, we're estimating that this is going to cost us about $4 million. That assumes 90 percent match for MMIS certified States and the regular match for others.

By the way, we have authority now to do this without seeking additional legislation. Some of these proposals we do not have authority to do right now. There are a couple of legislative packages being prepared and one will allow the Secretary to mandate certain requirements, setting certain standards and this sort of thing. This assumes that OMB approves it and the Congress approves it.

These are the kinds of things we're thinking about; whether or not they finally get through, we'll see. And in those instances where we don't have authority now, if we don't get the authority through legislation, obviously they're not going to be taking place. But this one we can do now.

The next one is a Common Medical Procedural Terminology and Coding System. CPT-4, is the proposal of the team. Twenty-nine States are now using a five-digit number plus a modifier and sixteen are using a CPT base.

This proposal would have the least harmful effect on Medicaid and would have a more harmful effect on Medicare. CPT-4 is a good system insofar as it identifies very discrete procedures. It's a very detailed system. For instance it provides something like five or six different kinds of office visits. On the other hand, by using such a detailed system, we do run the risk of significant inflation in the reimbursement practices with providers having a tendency to indicate the more expensive of selected practices.

At least on the policy level, we're not going to have specific reimbursement rates for each one. Probably there will be some other procedure, either grouping them so that any office visit gets the same amount of money regardless, or some other way of dealing with it.

We're very concerned that if we go with the system like this, it's going to cost us $25 million just to put it in place. That's the estimate today. If it starts costing us program money besides, then obviously it's not a wise choice, and we think we can set it up so that it won't cost us program money.

We're expecting an implementation schedule. I haven't seen it yet. Again what we're dealing with is draft papers that have to go through the regular process within HCFA; the Administrator has to sign off on them, and we then have to go through comments in other parts of the administration before we actually implement.

So we're talking probably about implementing these difficult ones at the earliest at the beginning of the fiscal year which is nine months from now and it probably would be later than that. That's my guess. That's not official HCFA policy, but, then again, nothing that I'm telling you today is official HCFA policy.

Common Claims Forms for Physicians -- we thought it would be a nice idea for physicians not to have to have a Medicaid claims form, a Medicare claims form, a Blue Shield claims form, an Aetna claims form, Travelers, etc. As you probably know, there's been a group working with the AMA and the health insurance industry on a common claims form, and that is the form that we are recommending. We call it the AMA form or the health insurance claims form.

Now, there are several problems with this. The form as it's designed does not provide enough detail for most Medicaid State agencies, and we know that. What we're proposing is a revision, which will provide what we believe will be enough data elements to satisfy probably almost all of the States.

But we recognize that there are still going to be some States who will insist on using additional data elements for their own internal use. There will be space on the form for that to happen. Basic forms will be identical, though. We think that this is a good idea because it will make it a lot easier for physicians to bill; it'll be easy when we're dealing with crossover claims, which we'll discuss later; it'll be easier if we ever get to the point of a single fiscal agent for Medicare and Medicaid processing the same kinds of claims.

So we think that these three particularly -- Common Provider Number, Common Coding System, and Common Billing Form -- are very important on the operational level as far as bringing the programs together and making sense.

A cost estimate here is around $2 million. That includes something like $300,000 just using up stock on hand. The proposal by the team is that the government would print the form and provide them to Medicare and Medicaid free. I'm not sure we're going to buy that, but we might, and provide it to other organizations at cost. That's the proposal; whether it will finally get out in that form, I'm not certain.

We have discussed this with AMA. Of course, we've been working very closely with them, and we've reached agreement where we have to reach agreement with them.

Uniform billing and discharge data on the institutional side -- this is a single project, but it really breaks down into two pieces, a uniform bill and the famed UHDDS, Uniform Hospital Discharge Data Set.

As far as the uniform bill is concerned, UB-16 is what is being experimented with now. A demonstration is going on in Connecticut, and one is going on in Arizona. New York State is using UBF-1 -- and there are a couple of other States thinking about trying it out.

It's difficult for me to tell you what's happening with UHDDS. It is being worked on a different level; with the Public Health Service.

There's a task group set up. They will be working on a notice of proposed rule making for a reg that may come out in March. What exactly it's going to say, I don't know.

Now, I have a problem with the way this project is working, because it doesn't seem to me terribly logical, especially on the provider side, to be dealing with all of the conversion costs that you're going to have to deal with in new forms, if a lot of your providers are already dealing on tape-to-tape. Do we really need to have a discharge data set at the end plus a paper bill on this end? Is there some way that using the technology that exists today, and that we expect will certainly exist tomorrow, to come up with a simple method perhaps using one of those documents to service both purposes, perhaps doing away with paper altogether and dealing with tape-to-tape, perhaps doing away with billing entirely and working some other way?

So while we are dealing with these demonstrations that we're working on, we're also taking a look at the whole issue of provider billing and provider data sets and seeing if there's a better way to do it.

One of my favorites is one innocently labeled Common Application of Level of Care for Skilled Nursing Facilities. Medicare and Medicaid use the same regulations when they determine level of care for patients in skilled nursing facilities in those two programs. However, the guidelines that they use in actually determining whether or not to pay for those people are not the same.

We had thought that what was happening was that Medicare was too conservative in its interpretation, thereby costing Medicaid money by not paying for people and for days that Medicare should be paying for; at least this was the Medicaid point of view. However, we have been doing some analysis and we found a couple of things.

One, Medicaid isn't entirely blameless, insofar as they're not paying for things that they could be paying for now under the regulation, but the guidelines either don't take into account the new reg which was about four years old, or else for other reasons the States have limited money, and ways they limit that money is by saying, well, we can just pay for so many days or so many services.

So, that's one piece of it. We're going to get them together. We're going to get them common guidelines; we're going to make sure that they're interpreting these the same way, so that if both programs look at a bill they're going to come out with pretty much the same answer most of the time.

Second piece, though, is as we're getting into this, we're finding that a lot of people in skilled nursing facilities shouldn't be there. They should be perhaps in an ICF level of care. This creates a whole new can of worms, because it's a lot of money that we're talking about. If

that's right, then, there's going to be real problems as far as who's paying for what and why, what the Federal share is going to be, getting new regulations and new requirements as far as the interpretation is correct to make sure that you only pay for ICF -- when it should be an ICF level, and SNF when it should be an SNF level. This is an unexpected side achievement I guess, of this group, to find this out, and I think it's going to cause a problem because it's going to be a lot of money that's going to cost the States.

Common coverage for laboratory services is finished. The first one was done by the people in the Division of Information Systems in Medicaid. Bob Young was the project manager, and I think he deserves some thanks for getting it done first. It's a relatively simple one, not to take anything away from Bob, but it's something that's been bothering people for a long time. States have been paying for services in labs for which the labs are not certified.

It's one thing to say that the lab is certified; it's another which services the labs are certified for. We know that very often they only go to the first level, so if the lab is certified any bill gets paid. We provided instructions to the States reminding them of the regulation that exists, telling them what they have to do. We have provided them with listings which will demonstrate which labs can do what to whom. Medicaid has put out an action transmittal saying that it will be part of the MMIS certification process from now on, and we will be monitoring it. We'll be monitoring it through BPST, which you use, and we'll be monitoring it through the State assessment process to make sure that you're only paying for those services that you should be paying for.

Processing of Medicare and Medicaid crossover claims is one of the most complex projects that we're dealing with. How do we straighten out the problem for these approximately four million people, fifteen percent of the recipients in the program, who are entitled to benefits under both programs? Medicaid is supposed to be the last payor, and you know the problems with third party liability. This is a piece of it as far as Medicare is concerned.

This relates to another project that we have, so I'll talk about them both at the same time. What we're doing is a couple of things. One is we're trying to get changes made to the HI master file to make sure that the information that the States need to determine eligibility is available.

We're making changes to the BENDEX, which is the basic tape that comes in that tells you who's entitled to what, so that it will provide information that you need. We're going to provide some procedures so that BENDEX goes both ways; it comes to the States; you do some things with it, provide it some information; it goes back to Social Security; they update their files; and it comes back again. It's going to be a circular process, and we're going to try to keep it as current as possible. So the data exchange between the two programs is one piece of this project.

We're going to improve that, and it's going to be improved shortly, we hope, rather than taking a long period of time.

Secondly, we're looking for demonstrations to see whether it makes sense to have one program process for both. Initially we had said, well, we thought Medicare would do it for both programs, and then we said, well, maybe that isn't fair, maybe Medicaid could do it also. Now, we're sort of coming back around and saying well, we don't think it makes a lot of sense to have Medicaid do it, because they would have to be duplicating a lot of systems that Medicare already has.

We have one demonstration that we're working with now in the State of New York, using the Division of Direct Reimbursement in Medicare, the Health and Hospitals Corporation in the city, and New York State's DSS, to see if we can come up with a system where in those cases where there's dual entitlement, they come into DDR; DDR pays both pieces, sends it back. We think that it will work. We think that it will wind up with getting HHC paid quicker for the whole piece, and we think it may be a way to go. As I said it's only a demonstration. At this point we're still negotiating.

We're interested in some other sites for a similar kind of a demonstration. We've received some suggestions, some offers from some States already, and we're responding to those. If you have other proposals, please let us know.

We have a number of projects that we say are management related. The first one is common PSRO monitoring procedures. We thought it made sense to have Medicare and Medicaid using the same monitoring procedures, PSROs. We learned that neither program thinks that true, nor does HSQ, nor does anybody else, so we cancelled the project.

What we're going to do is make sure that the Medicaid monitoring that goes on is supplemented by all of the activities of Health Standards and Quality, that they provide the information to the States, so that you know what's going on as far as they're concerned. Then when you do your monitoring, you feed it back to them, so that we have as full a set of information as possible. This has not been happening because HSQ has not been giving the information out, and it's not been happening because all States have not been sending the information in. We're going to set up some procedures for that, but we're not going to have a common monitoring; we're not going to be doing any more than we're doing now as far as making suggestions as to how you monitor PSROs.

Len Schaeffer mentioned performance standards on MMIS. We're taking a look at the whole issue of standards, starting out with fiscal agents, Medicare and Medicaid, to see whether it's appropriate to have any common standards between the two programs.

With all of these, except for the ones we've already got papers that

say, "Yes, we should do it and this is the way we should do it," we're not going in with the point of view that this is what it should be. It's the point of view: should this be and if so, how? We want to see whether or not it's appropriate to have common standards. If we do have them, at this point, they will probably start out at least basing them somewhat on the Medicare standards, since they are something that exists right now, or will exist shortly when they complete them. We will look at those and see how they fit. I'm not certain that we will be using them extensively. I think that probably over the long run that it will only be a jumping off point, and that you'll see a different set of standards.

We have a project called Common Workload and Administrative Cost Reporting by Fiscal Agents. We'd like to have common measures between Medicare and Medicaid, for: how long it takes to process a claim; how many claims you have on hand and how many days work you have; what your workload ratios are; what your production is; and what your administrative costs are. And then we'd like to be able to make some comparisons. Can you compare a fiscal agent from Medicaid with a contractor for Medicare? Well, certainly, sometimes you can't, but sometimes, perhaps, you can.

The problem that we've been facing basically is one that I'm sure that reasonable people can resolve. It relates to the definition of a claim.

Medicare defines a claim basically as a piece of paper that a physician generally will send in for an individual claim and for an individual set of services, which could be over several days, or could be different kinds of services.

Medicaid's definition is basically that of a line item. For each line item, they're calling that a claim. As you can see, there's a good deal of difference between the two definitions, and we're striving, mightily, for compromise. It's a very difficult process, and I think what's going to finally happen is that we'll decide not to define a claim at all, and just do something else entirely.

Joint review of fiscal agents -- there are ten States now which enjoy the same fiscal agents that Medicare does. For those, we'd like to see if we can have a single review do the Medicare and Medicaid review. What we mean is not necessarily 86 people come in for three weeks and stopping the operation while we are reviewing. Probably what it means is that it would be based on the kind of review that Medicare does now, a contractor evaluation program. It takes pieces of the program, reimbursement, claims processing, administration, and does a piece and then does another piece in another month, so that it's much less disruptive to the organization.

What we want to see happen for those pieces where it's likely that there will be similarity, for instance, provider reimbursement, is have Medicare/Medicaid go in together. Why should Medicare go in and Medicaid

go in a month later? For those obviously where there is no similarity, there's no point in doing them together. But we are going to try to reduce the burden on the States and the fiscal agents by doing the single reviews like this.

A further goal of this would be to have a similar review process between the two programs. As we move towards getting the two programs more similar, it becomes more logical. At this point it isn't obviously, but in a year or two, when things start to change, when we start getting common claims and common numbers, and all these things, then it would make more sense.

We have a project called "Common Terminology and Policy Systems Contract and Financial Management" and that's related to another one which deals with consistent regulations and policy documentation.

We have defined some common terms, you know, secretary, administrator, HCFA, things like that, because, interestingly enough, Medicare and Medicaid don't define them the same way, and we're going to make up a definition.

One of those in the list of the initial 25 is claim. We'll see what we can do with bringing the language more closely together, getting our regs more closely matched, getting instructions more closely matched, this sort of thing.

We have just sent an NPRM to the Office of the Secretary, and it should have been released or will be shortly, on consistent policies on issuing and withdrawing agreements for SNFs participating in Medicare and Medicaid. What all of that means is that when a SNF starts participation, both programs don't necessarily start at the same time. And we'd just like to see that they start at the same time, if they meet the same requirements it does seem reasonable.

Common offset procedures: if you owe Medicare money, or if you owe Medicaid money, we're going to get reimbursed. If you're in one of those programs, we're going to offset against that program. So, if you owe Medicare money and you're dropping out of the Medicare program, but you stay in Medicaid, Medicaid is going to offset those overpayments, and vice versa.

To do that we need legislation. It's in the legislative package now. And we assume that when that gets through the process, we will have it and you'll then be able to do this.

The last one that I'm going to talk about relates to EOBs, similar and improved explanation of benefit forms. As you know, Medicare provides EOBs to all of its recipients who receive non-institutional care; Medicaid does this on a sample basis.

Medicare has really started this project and we're sort of tacking on to it for Medicaid. Medicare is trying to get a better EOB, one that makes more sense to the recipient. Because you know, if you've seen them, very often they are indecipherable, you just don't know what they mean.

We're going to put them in a format, that shows in very simple language what happened, to whom, by whom, for how much. And it will say something like "Doctor Smith took out your gall bladder, he billed "X", we paid him "Y", and, why we paid him "Y".

In addition, we're working now with Medicaid and we've got a task group set up now to try to do the same thing on the Medicaid EOBs, to try to provide language that you can use; it will be computer generated and you'll have stock language that says for a cholecystecdomy, this is what you say, and for this, this is what you say.

And we're also going to try to have the form look similar, so that if you're a cross-over claimant and you receive an EOB from both programs, you'll know that that's what it is, they're going to look alike. They may be a different color, they're not going to be identical, but they will be similar.

That's the projects. Now, let me say a couple of things I forgot to say about the common claims forms for physicians, the non-institutional piece. One, we are working now on developing on OCR readable form for those States that use optical scanning. We are aware of the issue and we're not going to ignore you.

Secondly, the 1490 that Medicare uses now is adequate for its needs, so they don't really need any changes. But it's a much simpler form for beneficiaries to use. And a good portion of Medicare bills is from non-assigned claims, where beneficiaries submit the bills to Medicare. The health insurance form is so chocked full of data elements that a beneficiary who is over 65 will probably need a magnifying glass to read it and they're going to be unable to fill it out.

What Medicare is doing now is experimenting with a short form 1490 designed just for non-assigned cases; a very simple thing, a big piece of paper, with big blocks, it just says: name, address, social security number, and probably signature, one or two other items, and you staple the bills to it. We're going to try to do the same thing with this bill so that beneficiaries will also be able to use this, too.

We started out with 20 projects, we finished one; we've closed down one and we have combined two, so now -- what does that come out to -- 17? The number 20 has all sorts of mystical meanings. So, we're going to try to add three more projects.

Let me see if I can think of three: common beneficiary identification numbers, a very logical extension of common provider ID numbers, common claims numbers and common claims forms.

This was one that was in the initial group to be done, but it was taken off because we found out that Social Security was going to be doing some things to its numbering system, not to the basic nine digit number, but as it related to Social Security claims. Because of that and because we understood it was coming relatively soon, we did not want to get into this and then have to change again.

We now understand that the target date for Social Security's implementation is around 1984. And if that's so, and we're going to be verifying that before we go ahead, we're going to introduce common beneficiary identification numbers to our integration activity. I don't know what number we're going to use, but I would not be surprised if it was a Social Security number.

What I'm saying to you is this whole presentation is based on what our experience is so far, it does not at all reflect HCFA policy. I have to say that because I don't want you to go out tomorrow and change your whole system because I said we were going to have a nine digit number.

We want to take a look at the quality assurance programs that exist in Medicare and Medicaid and see whether there can be commonality, and if so, what it would look like.

We want to take a look at systems, Medicaid systems, Medicare systems. Medicare does not have an MMIS and they have certain standards their processes have to meet. Medicaid, of course, has MMIS in a number of States and more States are joining. We'd like to see if there is any purpose of having a similar system between the two programs, and, if there is, should it be MMIS or a derivative, should it be something else.

Again, all we're doing right now is just taking a very basic look at the issue of systems in the two programs and seeing what gives and what should be happening over the next few years.

My experience has been that MMIS is a much more comprehensive system than what Medicare has. And it's conceivable that we would see whether MMIS fits in the Medicare mode and whether it would pay them to start introducing that. I'm not sure that it does, we'll just take a look at it.

One of the things suggested was that we experiment with a single processor for Medicare and Medicaid in a State on a demonstration basis. I think it's a terrific idea; it should be a lot of fun to try it and see what happens with it. There's a lot of similarities, we think, and that would then give us a chance to test to see whether MMIS or something like that works in a Medicare mode.

So, we are beginning to take a look now at the concept of a unified claims process. And over the next several months we will be doing some staff work to see whether or not we should be going ahead with it. The

issue is whether we should go ahead with it, and at this point we just don't know.

Those are, generally, the areas that we're going to be taking a look at over the next couple of months to be adding projects.

I've told you very briefly what we're doing; I've given you some idea before many of the HCFA staff have gotten an idea of where we stand on a number of these projects, as far as these draft papers are concerned; they've only gone to the HCFA executive staff yesterday.

MMIS Benefits and Evaluation

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MR. NAKAMOTO: The program said "a State panel to be announced." The idea was that after I summarize the benefits of evaluation of MMIS, if there are any hardy State folks left, since we are recording this session, you can identify yourself and add to my list.

In the preliminary agenda, there was an item there called "Federal Regulations," and that was scratched because of the lack of time. In your packet, there were two regulatory pieces: the Medicaid regulation effective October 1, which is a rewrite of the entire Medicaid regulations; and the other piece as it relates to the FFP, Federal Financial Participation on ADP.

There are other regulations that we need to pay attention to especially in the R & D area, and R & D has its own set of regulations. Oftentimes we see R & D applications coming into Washington, or an application coming into Washington for 90 percent money, which should have been more properly channeled, and there is some back and forth that takes place.

You also need to be aware that the competitive procurement regulations are being updated by OMB. There was a new set that was announced, a Notice of Proposed Rulemaking. The White House OMB had a hearing on January 20th. The final comments are due January 31, I believe. The new Medicaid regulations also have a whole list of sections in there relating to fiscal agent contracting.

By way of emphasis -- and Len Schaeffer mentioned this -- we do plan to get active with what is called the National Technical Advisory Group and we will be talking with several other groups while we solicit advice from this group. I have already talked to different elements of APWA and the National Governors' Conference staff, and they are willing to participate.

I think Dick Heim mentioned the MMIS Task Force, and he identified some of the Task Force members. If you will, I would like to read about three or four sentences about the MMIS Task Force and how it got established. This is in the preamble of the MMIS Task Force.

It says: "working with Inspector General Tom Morris, HCFA Administrator Leonard D. Schaeffer has established a Task Force to evaluate present MMIS and recommend ways to strengthen it." The primary purpose of the HCFA Task Force is to develop and implement a strategy which identifies specific action steps, be that administrative, regulatory or legislative, that needs to be taken in order to maximize the benefit of the Medicaid Management Information System through the establishment of performance standards.

Upon approval and acceptance of Task Force recommendations and plans of action, HEW managers in each affected functional areas will direct specific implementation of actions required for the effective management

of the Medicaid program.

We have a Task Force which started about two weeks ago. We are in the process of negotiating for a contractor who will be on-board by the end of next week. The first set of recommendations will be due the middle of March, and if they are accepted, they will be assigned to the line agencies in HCFA and will be moving.

The Task Force life expectancy is about six months, and we will be talking to many of you here in this room and others. We will be visiting around the States. We do plan to have a one-day meeting for the industry, which will be announced in Commerce Business Daily, so that we can have a vehicle whereby the private sector, on some equitable basis, can come forth with their ideas.

As some of you in this room know, I always like to come up with a saying or two, and the saying that I have come up with -- and you might have heard this before -- goes like this: With an effective management system, you can have a chance to succeed in managing the Medicaid program. Without one, you are almost assured of failure. I think all of you in this room probably realize that or if you didn't when you came here three days ago, you do now.

The benefits of something like an MMIS are almost obvious and do not need repeating -- you need an information system if you have to have the capacity to operate and to operate efficiently. You also need it for the purposes of accountability.

You also need it for measures of cost control whether by paying the proper fee, paying for the proper eligibles, whether you are handling disallowances, duplicates, third party liability, utilization control, and so forth.

You also need it for the soft dollar avoidance or cost avoidance, and the cost savings and cost avoidance may not necessarily mean the same thing, depending upon how you define them in your particular jurisdiction.

One of the things that a sound information system does is that it fixes responsibility for organization decision and provides a basis of action. In order to have an effective information system and especially if you use a lot of automation, the only way you can get automation accomplished is by having a basis for making a decision. It also provides for flexibility in the sense that as policy changes are made, it is much easier, even though it may take a little bit of time at the beginning, to program the computer and let the computer make the massive change rather than to do it by hand.

I mean it is inconceivable that you can adjust a professional fee schedule, or a drug formulary, or codes as it relates to the eligibles for millions of people through a hand operation.

It also provides, if you put in the right kind of input -- and it doesn't necessarily have to come through an automated information system -- but perhaps a combination of what you have in there, plus surveys and other kinds of inquiries, the basis for policy changes and legislative proposals. It also provides, as Bill Hickman and Al Dobson said, a way of reporting on what happens, be that to your legislator, your interest group, the Federal government, et cetera, and as Tom Morris puts on his list, Number 1, a basis for providing information for fraud, abuse, and waste activities.

That is my simple categorization of benefits of something like an MMIS. I would like to come up with another saying. Oftentimes we see MMIS put in and left alone, and I say this: To leave an operational MMIS system alone is a sure way to commit administrative suicide.

I think Len Schaeffer kind of hinted at that. When we go out and start to revalidate the system, we are going to find some kinds of administrative suicides out there. And in order to do this evaluation, I think that we need to make a conscious commitment to make a maintenance and an improvement project.

I think there is one significant difference in the so-called new regulation effective October 1. It used to be that you got 90 percent money for design, development, and implementation, called DDI. We put in another "I." It is called design, development, implementation, or improvements.

I think, as States become aware of that, we will be seeing more APDs perhaps on an incremental basis as to what is meant by improvements. So, if you would read the regulation, we have not defined improvements, but I would expect that the States will be coming in with some improvements.

The other big thing that we probably need to be more aware of -- if you look at the cost of automation, the administrative costs of automation, it is between 30 and 50 percent of the budget.

I ask the question: Is your organization and is your management sufficiently tuned, knowledgeable, et cetera, to handle a technological change of that kind of a massive dollar in a large organization affecting a large program?

I submit that most of us, including the Federal government, but especially the States, have a long way to go in having experienced and knowledgeable managers to deal with the technical change. As we move to things like the "less paper" society, instead of printing out reports, to put them out on print tape, to make micrographic available instead of hard copy, and so forth, I suspect that most organizations, especially if you look at top management level, are not really geared to addressing technological changes. I think that there should be some homework done in this area.

Well, to sum up, you all know that MMIS is a necessary management tool. It is something that you either have to learn to live with, and if you can't learn to live with it, you need to do something else.

With that, I would like to close my comments. If I have missed anything in my categorization about the benefits or evaluation, which I have oversimplified, I would like the State panel out there, if you will, to make some additional final comments. Since we are recording this, your name will be in the proceedings if you do have any additional comments.

You have all been a good audience. I admire the tenacity of the group to stay this long with it. I think we have all learned something.

Thank you.

PANEL: SUR as a Management Tool

MODERATOR: Richard Heim

STATE PANEL:
Herbert Alfasso, New York
Denise Chuckovich, Idaho
Linda Stella, Minnesota

CENTRAL OFFICE RESOURCE:
Dan Boyle

MR. ALFASSO: You know, as John Hall was talking this morning, he made a biblical parable about his MMIS certification. I was wondering what he could have done if he were in New York State with the director -- with the name of the director of our MMIS program, Moses -- Lloyd Moses.

Let me go back to discussing the background of the MMIS in New York State. New York State is probably unique in a couple of respects, one of them is that the Medicaid program was never operated at the State level until the enabling legislation for MMIS went through, until that time we had in effect 58 local systems.

So, with the MMIS we were not only able to assume responsibility for the program, which we should have done, really, all along -- it just lends itself to that -- but it also meant that we had greater means to standardizing the program in New York State -- standardizing because there were local variations that were permitted. Of course, it initiated the utilization of EDP or automatic data processing everywhere. Some counties do have a very good system in New York State, or fairly good system, some have appalling systems; now we'll have a uniform system of data processing throughout.

Now, with the SUR system we are very concerned about the fact that SUR had a reputation, and probably still has a reputation, although there are many new systems coming into play which eliminate some of the problems of SUR -- of being a tremendous paper-generator, computer-burner.

What we did, before we designed the SUR system, was to visit other States. We went to visit other counties, those that were doing surveillance and utilization review; we talked to our users. And we came up with about five things that we knew our SUR system had to have. We also knew that we had to stay faithful to the Blue Book, and that's sometimes a tricky thing to pull off.

First of all, we knew that the profile -- the profile is a series of statistical items that we prepare for a physician or a group of physicians, or any group of providers, or recipients -- had to be flexible. We knew that the questions that people weren't going to be able to tell us now what they were going to need, let's say, three months from now, much less a year from now.

So, the profiles themselves had to remain very flexible. And today, for example, we might be interested in the high rollers, high volume providers; the next time we might be interested in the providers' prescribing patterns to put into play some educational program, perhaps. So, we need to have flexibility in the profiles.

We also needed flexibility in the peer grouping. If we're going to group our recipients and our providers, we couldn't very well stay with the same grouping patterns, we had to experiment with that. So, we had to be able to regroup our providers.

And SUR did not allow this. Once you decided on how you are going to group -- let's say your recipients, by age and sex and geographic area, you're pretty much stuck with that. We needed flexibility, so that we can regroup the recipients and regroup the providers, so that when we do exception reporting, we're doing it on the most meaningful kinds of peer groups that we could possibly have. And we had to be able to make these things on a run-to-run basis, without having to reprogram; that was very important.

The third thing is that we needed to look at every single participant in the program. We needed to look at every recipient and every provider, but we could not tolerate having reams of profiles being kicked out of the computer with many analysts' hours time spent on trying to pick and choose among those that they wanted to investigate. We had to have some kind of scoring method, some kind of ranking method built into the system.

We had to keep the amount of paper down. SUR is known to be a tremendous paper producer; we had to have a technique for keeping the volume of paper down. And, of course, this ties in very closely with the ranking device that we wanted to have in the system.

The reports had to come out on a timely basis. We saw States which could not rely on their SUR reports; they had to go to other things. And there are other things available because the reports were just not being produced on time. SUR, in most States, is a low-priority, heavy volume kind of thing for the computer. And this was something that we also had to have in our system.

Our SUR system does an excellent job on all of the flexibility areas that I talked about. What we do is we tell the users to tell us exactly what he wants for each run. We have a user manual, which tells them exactly how to fill in the forms that he must fill in, in order to tell us what he wants. It's a control file operated system, but those forms do not dictate the control file; what it does is inputs to us. We, in turn, take those data and prepare a control file which takes us about a week per category of service, to test out and so forth, it would take us maybe two weeks. We allow ourselves, I think, three weeks.

So, that's a much shorter time than it would take if you had to reprogram. With those control files you can do all of the things I mentioned before, with all of the flexibility that we wanted. I'll go into a little more detail about the system itself, in a few minutes. At any rate, the system itself as it developed, is like a specialized sophisticated report writer.

Now, as you know, SUR does basically, two things: it's a detection device and it's a profiling device. Let me describe the profiling a little bit and then I'll go into describing the detection.

In the profile, the user can dictate exactly what he wants to see on

the report and the content of the report. We have a lot of bells and whistles which I can't go into now, but suffice it to say that he can write items such as the number of claims, number of dollars, number of recipients, those general types of items. He can write very specific items, such as number of females between the ages of 10 and 15 who are given a specific type of injection. If that's what the user wanted for that particular run, he can write those items and have that on the provider's profile. And he can develop averages and ratios and so forth, based upon these items. In other words, he can have a report which is 250 to 300 items long, and that will be the profile for the category of service.

Now, in the protection end -- and this is very important -- the user wouldn't use all 250 items; he would only want to make his exceptions on the basis of only five items, six items, something like that. The user can determine every time he runs which items he's going to use. If he's interested in high-volume providers, let's say, he can use items such as number of claims, number of dollars, number of recipients, etc. If he's interested in something else, he can indicate ratio of first visits to total visits, as his exception item. And the processing for exceptions will be done only on those items that he's specified.

The user can assign a weight to those items, so that if he choses, let's say five items, some items might be considered more important than others. He can assign a weight to the items to give him the relative weight that he wants to see.

This itself, by the way, is not unique with us. Other States have had this kind of system, but the ultimate output is that the user's first report, when the SUR run is complete, is a severity index with a ranking of all of the participants who accepted in descending order. That would pretty much dictate his work load. He could just select the first hundred people, the first two hundred, this comes out by class group, and have his work load determined. He can also force certain people to come out, if he wants to.

But I won't go into all of the options that the user has. It's sufficient to say that all of the exceptions are not truly exceptions anyway, they are just simply people who deviated from the criteria. He may have, let's say, 20,000 recipients who kick out of the system, but he wouldn't be looking at more than 1,000. But those 20,000 are not necessarily abusers of the system, they just simply have a rank of some type. At least he has a method for determining which ones really deviated and can pick on those.

What I'm struck by whenever we talk about SUR is the fact that invariably SUR will have a low priority in the development and implementation of the MMIS, except for two times. The first time is certification time. We manage to do a lot of things for SUR during the course of the implementation of the MMIS. And the other times that I've heard is when

the first major run goes through and how much time everybody is now surprised at finding out it takes to run SUR.

Just to give you some statistics so you can compare it to your own State. We will have about 2 million recipients. We have over $3 billion worth of expenditures. We have 10,000 physicians in New York City alone, not counting other types of providers -- huge volumes.

As far as what we've implemented so far is concerned, we've produced SUR reports on physicians, on pharmacies, and on clinics. Clinics I don't think are very big in most other States, but they're very large for us. Out-patient services account for about four or five times the amount of money in New York City as does physician services. And we produce SUR reports on recipients.

In the last SUR report we processed 20 million claims that covered up to September 1978, roughly 10 months. And we expect that the SUR system will have to handle about 80 to 85 million claims in a 15-month period.

Now, as far as utilization of the system is concerned, the first impact was interestingly enough with the group profile reports, the reports that told us what the groups of physicians, groups of clinics and so forth were doing. Remember, there are profiles for individual recipients and providers, and there are profiles which talk about the group.

For the first time, we were able to get an enormous amount of information which absolutely fascinated the top management. I don't imagine this will continue to occur. But the information we received on physicians by specialty, which specialties were costing so much, what kinds of things they did, these profiles were absolutely revealing. And they had a great impact, a great deal of analysis was made that was sent to the Commissioner.

As I said, because of our poor data base, we were not able to get these statistics in the past. So, those management summary reports were very impressive. We produced management summary reports, obviously, on all types and they were interesting for all categories of service. Recipients were fascinating, as far as their utilization patterns were concerned.

But that's not the main purpose of SUR. The main purpose of SUR was detection of individuals that we wanted to pursue for follow-up. And in this area we've done our beginning work with recipients. I didn't expect that to be the case, and I'm not responsible for determining which we would look at. I guess what occurred here was that there was interest in getting some immediate payoffs and New York City was interested in working on a demonstration project with us. I think the Secretary of HEW, when he was in New York City for a press conference recently, mentioned one of the demonstration projects in which we took recipients who were visiting many,

many providers and those came out of the SUR system. We just simply asked the question and kicked out recipients on the item number of different providers. We had one recipient who saw 17 different providers and then, one other who saw 12, and then lots of them who saw eight -- this is in a three-month period. Based on those reports, that detection device, we were able to pick recipients -- I think 119 of them -- and we limited them to just one pharmacy per month.

In his statement Secretary Califano quoted one of the statistics which showed that the recipient costs went down, let's say from an average of $250 a month to something like $15 as month, obviously a very big payoff.

As far as the provider side is concerned, we have a staff of 10 to 13 people in the State Department of Social Services. As mentioned earlier this morning, you need SUR staff. They are medically oriented, but what they were doing with providers is mainly experimenting with the system. They are just now about to start making recommendations for follow-up.

We also had some political problems, or jurisdictional problems in the State which tied up some money for SUR, and that was the reason we could not quickly get more staff on board. It was about a million dollars that we just couldn't spend because of jurisdictional problems.

Another use for SUR which you might find interesting is the tie in with EOMBs. Some States may still be sending EOMBs out on a 100 percent basis, I don't know. But since we have the option of sending it out on a sample basis, we do. We send up to 50,000 EOMBs a month, which is far in excess of what Federal government requires us to send. But it turned out to be very useful. Again, this surprised me. EOMBs are tied in very closely with SUR because the accepting providers are used as a basis for sending EOMBs to recipients.

There are other ways we can send the EOMBs, but we used SUR to determine which providers will be selected, and then from those providers, we select a random sample of recipients. This has turned out to be an excellent way of targeting in your EOMBs to those places where it would do the most good.

The payoff seems to be very good in two respects. For one, it seems to have identified new providers we didn't know about. We did have some investigatory work being done in New York State, of course -- fraud and abuse work. Some providers have been identified as having questionable practices, but eqally important, it's identified specifics and specific witnesses for people we already had under surveillance. We're changing our EOMB form, incidentally, to become more responsive to our needs. We need to go back to the specific claim the recipient is talking about and, also, to straighten out some questions of clarity on the forms.

As far as feedback to the MMIS is concerned, we've had a great deal of feedback to the rest of the system. On the pre-payment side, on the edit

side, we've identified questionable claims which were being paid.

We obviously thought to question the status of some of the edits. I guess in some cases when we have a backlog of pending claims we may have turned off or turned down some of the edits to pay status, and they turn up in our SUR reports. SUR will pick up all the garbage and display it. This is why we've been working very hard in trying to insure the integrity of the SUR profiles, to reflect accurate claims. Diagnosis edits have not enjoyed a high priority because diagnosis on the forms themselves have not been considered all that important, but we have been forcing that issue, with the diagnosis. In some cases we've succeeded and in other cases we're still working on it.

Provider enrollment has been another source of errors for us. We class group providers by type of practice, that is whether they're in individual practice, or shared help facilities, or group practice. It's a very important criterion and that particular item wasn't considered very important when we enrolled physicians rather quickly. We're now going back and straightening up the enrollment in order to pick that information up because it is very important to SUR.

Now, I've been asked to talk about dealing with control file systems. First, we have to train our users and that takes time. So, that could be considered a problem. We need staff on our side to take the information and prepare control files a great deal at the beginning of the system.

The system is prone to control file type of errors which can be a problem; you can't test for all conditions, it's impossible. It places a heavy responsibility on the user, but I don't consider that a disadvantage. I wasn't just speaking about advantages. The user knows exactly what goes into his reports, he tells us exactly how to define each item. There isn't the kind of quibbling you get or surprises, for users should not be surprised with what winds up in his reports. And then, also, with a system like ours, bugs tend to turn up long after you thought you had ironed them out.

I'll just mention three things dealing with the fiscal agent. We prepared the input. Our process: we prepared the input from the users' specifications, and the fiscal agent tests it out before it actually goes into production.

During the development of SUR, our relationship with the fiscal agent was actually excellent. I think part of the reason was the fact that we were breaking new ground and the system itself was very interesting. There was a great deal of pride on both the State's part and our fiscal agent's part in the development of SUR.

On the operational side it has not been so sweet, we have had problems. The fiscal agent did not really believe the figures about the running time and when he put it into practice, we had some problems with

the fiscal agent background.

Also, since the user can really dictate how long these runs are going by the control files, he can make it run forever. There is some concern by the fiscal agent that this could get out of hand. This is one of the areas that we're working on now. In fact, we're working on streamlining the system to make it a lot more efficient.

In summary then, I think the SUR system tends to keep the rest of the MMIS honest in terms of the kinds of data that we get into it. This is going back to it as a management tool and not talking about it as a surveillance and utilization review system. It does a lot better job in this area than MARS or even the claims reports can do because it goes into so much more detail on some of these data elements, and they're not really used very much by the other areas.

It's a very attractive system from the users' point of view because he has control over it and I think that tends to foster greater utilization and greater understanding of the system, also.

Also, I should mention that we're under very heavy pressure because of the system's flexibility. We're using it as kind of a research tool. People who are doing studies, let's say of transporting elderly people to New York City with a new transportation device want to use the SUR system to see what effect it has had on institutionalization. This is something that we have to watch because we have to give priorities to SUR as an exception and detection system, and the other use of SUR would have to be down-played. But we are under heavy pressure to use SUR as kind of a big report writer.

And that, basically, summarizes New York State's SUR. Thank you.

MS. CHUCKOVICH: This afternoon I would like to begin by describing Idaho's Medicaid program in general and our SUR program more specifically. Then I'll get into some of the benefits that I've seen management derive from SUR and some of the shortcomings that we've come up against. I think you're going to find the difference between Idaho's program and New York's to be quite remarkable.

First, let me tell you something about Idaho and Idaho's Medicaid program. Idaho is a small conservative State with a population of about 800,000 people. Our Medicaid program is also quite small.

For fiscal year 1979 we had a program budget of $41 million. We've got 29,000 recipients and 7,000 providers. Of those 7,000 providers, 4,000 are from out-of-State. A lot of our recipients live in border towns and they go into Washington, Oregon and Utah for their medical care.

In Idaho, our MMIS became operational in January of 1978, one year ago. We contracted with EDS, Electronic Data Systems, who takes care of all our data entry, microfilming, claims processing, and generation of reports. The State is responsible for all claims adjudication and claims control.

I realize the volume of our program must sound minute to most of you from larger States, and you must realize we also have a very small staff. Our entire staff, including administrators, professionals, claims adjudicators and clerical support, is only 24 people.

I think there's certain advantages to being a small program. System problems seem to be more easily recognized and rectified, and our staff is crosstrained out of necessity, so we have the background to relate from one MMIS subsystem to another.

In Idaho, as you might guess, our SUR program is also quite small. The staffing for the past eight months consisted of only myself. We're planning to add a second analyst next month, but up until now I've been the only person available to work reports.

Our SUR program produces provider profiles for eight categories of service; we have recipient profiles, hospital reports, and treatment analysis. My responsibilities have included working those reports, revising the report specifications to meet Idaho's needs, designing case development and disposition procedures, and developing some overall utilization review procedures.

Well, needless to say, that's a lot for one person. Faced with a shortage of staff, numerous responsibilities, and volumes of reports, I decided to direct a good deal of my time towards overall system revisions and policy development. While having been involved in several cases of individual utilization review, I felt I could be most effective during the early months of our MMIS working in more generalized areas. Today, I

would like to focus on the benefits of this more generalized work to our management.

During the past year, the situation in Idaho has been such that Medicaid management needed the kinds of general information SUR could provide. Prior to our MMIS implementation our program policy was extremely brief and vague. It needed a good deal of development.

I participated with management in developing a comprehensive new policy manual. The people I was working with had a good background in policy, but very limited knowledge of the MMIS. I was able to provide information to help coordinate policy with the MMIS and SUR. I was able to help with questions like how could a new policy be enforced by the system; how could SUR be revised to track this new policy from the back end; how much system work would be created by a new policy? I also provided input into development of the utilization review section of our manual to reflect SUR capabilities and the utilization review procedures which I developed.

The second area in which I've seen SUR be beneficial to management is that of system revisions. Idaho's new MMIS required a great deal of adjustment to become fine tuned to the State.

During my review of SUR data, I had the opportunity to identify numerous procedures which had been paid for, but were not in line with our policy. I recommended activation of claims processing audits to catch these procedures prior to payment. Activation of these audits brought our system into line with our policy and helped to save program dollars.

I think system revisions is one area where the benefits of my cross-training are pretty obvious. I've had experience in claims examining with the provider file, the eligibility file, cash control, and I do some work with MARS currently.

With this kind of background, I'm aware of the interrelations of the various MMIS subsystems and I'm, therefore, aware of the kinds of work that a new audit can create; with my SUR research, I'm also aware of the potential dollars to be saved. I can present this information to management with my recommendations.

The third area where I've seen SUR benefit management is that of program utilization. This fall, Idaho's voters passed the property tax initiative similar to Proposition 13 in California, and we're facing definite budget cuts and probable severe program cuts.

Facing this, management required research into utilization and costs in several categories of service to determine which program cuts to recommend. Using my SUR utilization information with MARS budget information, I did several studies for management. We looked at inpatient length of stay and rising hospital costs, at outpatient utilization, and the

utilization in State-sponsored clinics, to name a few.

This research not only provided important program information to management, but also gave me an opportunity to look at my reports in a new way. I was able to recognize elements of the reports which could be revised to be more effective, both in this kind of research and in individual utilization review, as well.

I've had the opportunity to utilize SUR to assist management on several occasions. I've also come up against numerous shortcomings in the reports and in the way that they are utilized in Idaho. When I talk about shortcomings, I think it's important that you remember that Idaho's SUR unit has only been active for eight months, and that certainly does influence my perspective.

The foremost problem in my mind concerning SUR in Idaho is one of utilization. Up until now we've lacked the staff to utilize the SUR reports as they were designed. And, from what I understand, this problem is not unique to Idaho.

It seems to me a vicious circle exists, without staff to work SUR the way it was meant to be worked, the results are not as effective or as extensive as they might be. Without those effective demonstrated results, management hesitates to increase staffing.

The second shortcoming I'm aware of develops from the nature of the reports themselves. It's a very lengthy process to adjust the reports to accurately reflect your own State. In the interim, the reports lack reliability in the eyes of management. There have been numerous times when my boss has come to me and asked for some piece of information, and I've had to say, "Gee, I don't have it right now, but next quarter we're hoping to get it." And invariably next quarter is just too far off.

It seems that the lengthiness of this initial report adjustment period is a fact of life. However, I feel that if States could provide for more support and staff time for SUR, earlier in the development of the MMIS, this situation could be alleviated and we wouldn't be making major report adjustments one year after implementation.

The third shortcoming I've noted relates to the two I've already mentioned. While management is skeptical about the usefulness of reports which seem to require constant adjustment and hesitant to increase SUR staff, those in management who are not systems oriented are also put off by the sophistication and complexity of SUR design. Without some knowledge of the flexibility of the reports, as well as their limitations, management cannot know what is possible to request, nor can they understand why some information is not retrievable.

I realize SUR staff has the responsibility to demonstrate the usefulness of reports to management. In Idaho on several occasions, I have been

able to provide management with information from SUR which has been beneficial to the administration of our program. I've also been unable to provide that information at times due to the shortcomings I've already mentioned.

In SUR I think we have a flexible, sophisticated tool and a wealth of potential information. However, from my experience in Idaho and from what I suspect is true in other States, SUR suffers from a lack of management support and at times management understanding. Hopefully with time, experience and increased demonstration of the usefulness of SUR, this situation will improve.

Our experience in Idaho has demonstrated SUR has a great deal of potential for providing management with a variety of information useful to the administration of Medicaid. I believe we could do a great deal more with our SUR program in Idaho, given the opportunity; and, I for one, would like to see what's possible for an SUR program with appropriate staffing, development and support.

Thank you.

MS. STELLA: First, I'd just like to say that New York is not unique, that Minnesota also had 87 different county administered medical assistance payment systems before MMIS was instituted. So we know what a hassle it is to try to get the State to pay the whole works.

In Minnesota the SUR subsystem was installed along with the MMIS and was approved in 1975, but during installation there wasn't a SUR staff and so we didn't really have much say into what went into the system. And when it was installed, two people were pulled out of provider education. They both had social work backgrounds, and they were told, "Okay, you're going to work with this new system. See what you can do with it."

Their focus, besides trying to validate the data that was coming out, was more recipient oriented. And when I came on board they were working with recipient limits, trying to set limits for our first reports that were going to come out. So the three of us were the unit for awhile. When we had our first printout in September of 1975, we ended up with two cart loads full of providers. We were strictly using two standard deviations; we didn't do much with it.

In September of '75, we finally got a director and he gave us a little bit of direction for our SUR system. We divided the unit into provider area, recipient area and then support services.

Our SUR division in Minnesota is completely self-contained. We have health professionals who analyze the recipient reports; they also have a medical background. I am the liaison between what the user wants and what we get out of the computer. Then we also have investigators on our staff. So, we can carry a case from coming off the computer, to the analysis, to the audit, to the investigation, to preparing it for the attorney general.

Now, as we started using our SUR program, during 1976, especially, we were becoming disillusioned with what we had. The Ohio system was rigid. We couldn't get out of it what we wanted, and we were going to SUR conferences in Denver and Atlanta and we heard about SUR II. It seemed like our type of system, because it was user controlled and it was very flexible. Our big hangup in Minnesota was that we didn't have dedicated computer staff, and, if we wanted anything done, we had to beg for it. It took a long time to get any changes made. So we were looking for a system that when the user wanted something done, it could get done, and we found this in SUR II.

As Herb mentioned, it's a control file oriented system. Anything that comes out on a SUR report can be put into that control file, and we will get an output. This is all done in the SUR division; we don't have to rely on systems staff at all. I do all the coding for the control file; I go to the user and say, "What do you want? What would you like to see?" And I tell them if it's possible to get it out.

We've done a test run on SUR II in June; we did a major run in

November. We used all categories of service and all recipients, and we've really gotten our recipient caseload down to manageable levels. On our SUR II run, we had 128 recipients come out, out of 211,000 eligibles. So the control of volume is possible; you just have to know how to do it. By working with the system, working with frequency distributions, we've managed to overcome that problem.

Now, as far as SUR as a management tool, we have recommended changes to front-end edits. We were involved with Project Integrity I, as I am sure everybody was, and it showed a major area problem in our system with surgeries, which we knew existed. As a result of that and some of the work we did, we were able to recommend some new front-end edits on surgeries.

We also use SUR as a check on policy, and do recent audits and computer runs, from leads like newspaper articles; our med-trans has come under fire, and we've recommended changes in the med-trans area. We also use SUR to monitor psych services. We have a maximum of 30 days stay in a psych hospital. So one of our items on our SUR reports is any stay over 30 days, and we are able to monitor those hospitals, or those doctors who are ordering stays over 30 days.

We also use SUR to monitor the provider file, and we found out that a lot of our physicians are on file without specialties. They weren't supposed to be enrolled this way, but somehow they got through. So we made recommendations back to the provider enrollment unit to get the file cleaned up; find out what the specialties really are; get the licenses to make sure they are on file.

We have used SUR in support of other research that has been done. There is one study going on right now looking at utilization patterns of drugs in long-term care facilities, using SUR data to work on this.

We've also used SUR to get data for Operation Crack-Down, because the Minneapolis-St. Paul area was chosen as one of the targets. We have used SUR data on a home health study that was being done, and we've also used it for dental studies. The data is there to use, and we figure why not use it. And we've had questions. Some people wanted to know what the utilization patterns of the AFDC children was as opposed to medical only children and we were able to give this data because that's how we had our class groups broken down.

We've also taken a road show with our SUR. Our SUR division has gone on the road to different counties, let them know what SUR is about. In this way, we are enlightening them as to some of the problems in the recipient area.

We do have a recipient-restriction program, wherein if a recipient is over utilizing, we can restrict them to one pharmacy and one physician to get their services. Restriction normally lasts a year. At the end of

that time they are reviewed; and, if they seem to have come around, they will be taken off restriction, but they may be extended if things have not improved.

We are getting more referrals from the counties because of this show-and-tell that we put on. We've also done show-and-tell with the provider groups. Tom Gaylord, who is the director, has taken the show to the pharmacy groups and the medical society, shown them reports that we can get off of SUR, and they are amazed at what we can collect on them. This may have some kind of a deterrent effect, the providers knowing that we are watching them, and we believe that they may have improved their practices just knowing that we are out there.

We've also done a road show just for the claims processing division. You know, they see a lot of the stuff that's coming through, and its gotten to the point where they were getting frustrated because they could see problem areas cropping up. So we told them all, if you see an area, refer it to us. We have gotten some very good referrals from claims processing on patterns that they have seen developing.

These are the major areas that we've found SUR to be useful for management. And besides the fraud and abuse areas, it has great potential in a lot of other areas.

Thank you very much.

PANEL: MMIS-PSRO

MODERATOR: Richard Heim

STATE PANEL:

David Farrell, New Mexico

James Healy, New Mexico

MR. FARRELL: I would imagine that some of you find it a little bit unusual to see a PSRO presentation at an MMIS conference.

I think it's probably quite unusual, but in New Mexico we feel quite comfortable and quite confident in talking about our role in Medicaid claims processing and review system here. We have a long history, first, being involved as a foundation for medical care and reviewing all Title XIX claims. Then moving on as a PSRO, and as, of course, time changed, our review system evolved and changed as well until we've arrived at the current configuration, where we think we've carved out an appropriate and helpful role for the State in providing a peer review component in their Medicaid claims processing system.

Because we have such limited time, we've prepared some slides and hope that we can get across some of the notions and concepts using this approach.

The presentation will be divided: first, three slides that are intended to give you some background to show how we're put together or structured in New Mexico. Then moving on, very briefly, to talk about the role we play in the review of the claims in the Title XIX system, and then moving into what we're really excited about. A new approach that we've developed here under the Health Standards and Quality Bureau Demonstration Project. And, by the way, that is now funded as an operational review program, because it goes beyond just being ambulatory.

What we'll be doing is talking about what we've called problem review. And, again, this was developed with Health Standards and Quality Bureau funding, and we think it's an exciting new technique.

The first slide is an attempt to show you what the PSRO program in New Mexico is comprised of.

Generally, in most States, we find a PSRO program confined to what we call acute care review. That's the in-hospital review component of a PSRO program and we do pretty much the standard kinds of things that are expected of a PSRO.

Over on the right, we have long-term care review; and, on February 1st of this year, NMPSRO is scheduled to assume review responsibility for long-term care review under Title XI. This doesn't mean that we haven't been involved in long-term care review, because we've been doing it since 1971, first as a foundation and then as a PSRO, under an agreement with the State Title XIX agency.

The discussion today will focus on what we've called ambulatory review, here in the middle, and we call these our traditional review kinds of activities. We'll be discussing them in more depth later on -- and then problem review, which kind of stands by itself as a Federally funded

activity.

The second slide simply lists what we've called the Medicaid management system or any other good claims processing system; the major functions that we as a PSRO recognize and, in doing problem review, attempt to influence. We could go into a discussion of each one of those; but, in the interest of time, I think I'll go on to the next slide.

This slide is a representation of the way in which New Mexico has put its Title XIX program together. Obviously, the Title XIX State agency is responsible for all activities, but has chosen to retain direct responsibility for program management kinds of functions, program policy determinations, establishment of benefit limits, and conduct utilization review; and, has contracted to the fiscal agent, EDS Federal, for carrying out the traditional kinds of activities associated with an approved MMIS system.

There is one major difference here in New Mexico in that EDS has assumed responsibility for maintenance of the eligibility files. The State has contracted out to the NMPSRO for, again what we'll call traditional review activity, that's precertification of certain services, prepayment review of certain claims and some involvement in the retrospective review of the SUR reports. Standing by itself, down here, not contracted for by the State, is the Federally funded activity of problem review.

What we mean when we speak of traditional review, as I said earlier, is the helpful role that NMPSRO has established in the Title XIX review system in New Mexico. Essentially, what we do is we run for the State a program of precertification. Certain elective procedures and certain types of services require that the NMPSRO deem that service medically necessary prior to the time the service is delivered.

The important point is that if we say no, we say no before the service is rendered and, thereby, avoid a lot of very unhappy providers. In certain instances, a service is already rendered and may be subject to prepayment review, depending on whether we've identified it as a service or even identified a provider whose claims need prepayment review.

Again, what we are involved in reviewing, in this case, is a claim for the service and are required to make a decision as to whether that service is medically necessary or not. Both of these programs introduce the notion of professional review with peers, peers being physicians or providers in the particular specialty that's being reviewed.

The retrospective portion of our traditional review activity involves the NMPSRO use of the SUR reports, and, we do share a report set with the State, by the way, in an attempt for us to determine whether a procedure, provider, diagnosis, and procedure combination should be subjected to review prior to payment. This is the mechanism that we'll be using to

determine who or what services get placed on prepayment review.

Now, what we really came to talk to you about today is problem review. And essentially what we've done is utilized or established a process by which the NMPSRO can address problems. Problems stand to have a broad definition in our system.

Item 1, problem generation and selection -- just as an aside you may find that if you look at this very closely this is kind of an abbreviated version of a medical care evaluation study in PRSO terminology or a medical audit, if some of you are familiar with the quality components of a hospital review.

But, Step 1, problem generation and selection in the problem review process starts from a different perspective. Instead of waiting for a quarterly report in a predetermined format to arrive, requiring analysis and an attempt to find some kind of anomaly in the data and then calling it a problem and then waiting to try to find a way to research that; we start with a notion that because of our involvement in review over time and the reports that are available, SUR, hospital profiles and so forth, that we're aware of a lot of problems. We use these other sources, but we are aware of a lot of problems.

What we do is generate these, and our problem hasn't been finding them; it's been really prioritizing them. The selection process that's mentioned requires that we prioritize them and get them down to a meaningful number so that we can work with the resources that we have to solve them.

Step 2, problem definition and research, is just that. Our effort in Step 2 is to verify, first of all, that a problem does exist, then to define it down to a point where we think we can do something about it, research the problem and perform analysis on it.

All of this activiity in 1 and 2 leads to what we call corrective action and we think we've put together a good array of the kinds of corrective actions that PSROs are interested in taking. Then, of course, any process involving working on a problem and then taking corrective action calls for us to evaluate and restudy to determine whether or not we've had any impact on the problem.

Step 2 in our system is so important that we put an extra chart up, just for a moment so you can see how we do this. How we do it is very important and goes back to the words that I was hearing in the earlier discussion, flexibility.

What do you do when you think you've got a problem? As I said earlier, you verify, define, research and analyze. But if you are going to rely on some sort of predetermined information and you're involved in variable problems, broad ranging problems, you really can't get the job done.

The MMIS report sets certainly provides good information and so does the PSRO hospital data set, but both are limited. Our MMIS report set has to be established in advance and arrives periodically. The PSRO hospital data set is confined to hospitals and isn't as flexible as we would like it to be at the moment.

So, in order to support this portion of our review system, problem review, we developed what we call RGAR, a Report Generator for Ambulatory Review.

Quite simply, what we've done is taken MMIS data into the system, by arranging for a tape transfer. We sort through it, rearrange it, make it more readily accessible and then, through a program that is controlled by staff of the NMPSRO, we provide flexible and timely access to it. We set the report limits that we want, the report format that we want, and we have turnaround time that's been less than a week, most cases.

Another way of taking a look at what we've done and another way of looking at how we avoided all the problems of getting involved in the MMIS process, is to state fairly what we did. We performed problem review without disturbing the process.

Basically, as I said, we take the information that's already available in the MMIS data base; we transfer it with a paid claims tape. We then select from the available data, repack that data, subject it to the process that I have already discussed. In step 3, we make recommendations that have the potential for impacting on all of the MMIS responsibilities, including the management responsibilities for policy and program, all the way down to the level of where we may be able to impact on some specific aspects of the claims processing and screening portion of the program, or in some ways on the way we perform our own review.

Now, we like to think that we've created a new kind of a system for doing review. The first thing that we did, under the demonstration project, was to create a management structure for managing this process. Therefore, we naturally went to something called the management committee. Then we placed the management committee in charge of running the process. Another way of looking at it as a system is that we made available to them all of the input sources that we talked about earlier.

In their problem generation and selection phase, they have available any of the analyses that have been made of SUR reports, in order to generate the problems, anything that came out of hospital profile analysis, any impressions, concerns that have come out of physicians or staff prepayment review experience, anything we've seen in MCEs, the study results, and any kind of outside referrals. All of these can be considered for action.

Moving to phase 2 we then have identified what the information sources are that will allow us to work on this. The heart of the system,

again, is the flexible report generator, RGAR; SUR reports are available as well as hospital profiles.

I said earlier that we had assembled an array of potential activities. Now, we heard a lot about fraud and abuse this morning. I think that you have to remember that a PSRO approach is a little different. Our notion is that a lot of these problems require education and that we can clean up a lot of the activity that is going on out there through educational feedback.

One of our mechanisms, therefore, is educational feedback, and it takes place in two modes. One-on-one could involve a letter, phone call, or even a personal office visit in an attempt to correct a quality kind of a problem. If we find a problem exists that's of a more general nature, we can often take the route of publishing the study that we did and the results that we achieved -- or the results of our analysis -- in a newsletter or in perhaps a scientific publication, if the study was done well enough.

We can then, if we find a different kind of a problem, place either the provider that's involved in the problem or the procedure or procedure diagnosis on prepayment review, and thus have moved that particular problem over to be addressed by our traditional review system.

We've developed a situation where, if we find problems of a certain nature, we might make recommendations to the State Title XIX agency about some of its policies that might be modified. We might make recommendations about review system modifications.

Having taken all of these actions, if we are really not able in our own minds to reconcile that we've achieved any kind of a change -- and the way we identify that is again through step 4, evaluation and restudy, if we feel we haven't been able to promote the kind of change that we think is necessary, we can always take the action of referring the recipient or the provider outside of NMPSRO to the Board of Medical Examiners or to the State Title XIX agency, where a different kind of process will begin.

Now all of this activity would lead to nothing had we not had some results to report. As a result of our activity as a demonstration project, we were able to convince the Department of Health, Education and Welfare's Health Standards and Quality Bureau that we should be continued as an operational system. So we've evolved from the demonstration project phase into an operational phase and are continuing this kind of review.

MR. HEALY: I'm the second and somewhat lighter half of the Dave and Jim show, and I really get the fun part of this presentation because I get to talk about the results of our demonstration project.

We began our demonstration project in October of 1976, and, really, the first year of the project was devoted to development of the Report Generator for Ambulatory Review and of a system for utilizing physicians and staff in a management role to select and define problems.

Once we began our second year of the demonstration project, we really went into an operational mode. We were able to generate over a hundred and forty potential topics for study, medical problems, utilization problems, potential abuse, things like that.

What we found was that our physicians were interested in performing studies of medical quality. They really wanted to try in a nonpunitive, non-sanctioning way to modify physician behavior when they found it to be a problem.

So they selected four drug problems. They selected steroids given to children with upper respiratory infections. They selected the use of the chloramphenicol as a potentially very dangerous drug in an outpatient setting since it can cause fatal aplastic anemia. They selected the use of tetracycline as an ineffective drug for upper respiratory infections; and, finally, they wanted to study the use of drugs given to pregnant women.

Finally, we selected two studies, tetracycline for URI and the use of chloramphenicol as having the best potential for physician behavior change. Also in the project, after narrowing our topics down to that level in the first half, we think we did change physician behavior in New Mexico. We also did a study of emergency room utilization, which we found very interesting and finally did a study of tonsillectomy in New Mexico.

First of all, in the fall of 1977, after we had gone through our developmental phase and were into an operational mode, we identified some 33 physicians who were found to be prescribing tetracycline for upper respiratory infection in the highest numbers.

We found that by contacting half of that group we could have the greatest impact on quality of care in this problem. We could also retain half of that group as a control group to see if they changed as well, and if there was anything else going on in New Mexico that might be responsible for the behavior change.

We had 17 physicians randomly stratified into our experimental group; and we found, in a six month period, after personal visits by our physicians to their offices, conducted in as much of a non-threatening way as possible, that nine of the physicians stopped prescribing tetracycline for URI at least to their Medicaid patients.

Only one physician in the control group stopped the prescribing in this manner. We formed a chi-square on this and found a level of significance at the .025 level.

We'd also performed an emergency reutilization study which our physicians really found to be fascinating. We identified the patients in New Mexico who had gone to the emergency rooms more than seven times in one year. We found a hundred such patients.

We also got a random sample of the Medicaid population who had not gone to the emergency room more than seven times. We found the average age of the patients of the high utilization group to be 33 against the 24 in the random sample.

This began to suggest to our physicians that, especially in an AFDC population, it was a little unusual to have such a high age and such high utilization. This group accounted for $34,364 in the emergency room alone in one year against $1,700 for the random sample.

Amazingly enough, for their cost per visit, the high group was only $28 while the low group accounted for $37 per visit. Again, our physicians attributed this to the fact that the high utilizers were perhaps abusers and were well known to the emergency room staffs.

The total cost of care to the Medicaid program in New Mexico for the high utilization group was $340,000 in one year for a hundred patients, while the random sample accounted for $41,000. This works out to $3,398 in cost per patient and $400 per patient for the random sample.

Our physicians found this to be so interesting that they decided to actually do a review of profiles of the high utilizers. In so doing, we had three reviewers independently look at a sample of the hundred patients, and they found that about 98 percent of the time, they felt from the data, that the patients were abusing the emergency room.

As a result of this, we've opened talks with the State agency and have made some recommendations concerning program policy change which might control this group.

Finally, we did a study of tonsillectomy in New Mexico Medicaid. We identified 150 patients who'd received a tonsillectomy in six months in 1977; ninety of those were eligible for one year prior to their surgery. Our physicians wanted to identify that one-year period because they wanted to look at episodes of illness.

They adopted criteria that said a patient had to have four episodes of tonsillary illness prior to having a tonsillectomy or had to have an episode of paratonsillar abscess or neoplasm. We found that 51 percent of the patients actually met that criteria.

Since there are between five and six hundred tonsillectomies per year in New Mexico Medicaid, at an average cost of $559, our physicians felt that some PSRO policy change could perhaps help to control this situation.

In completing our demonstration project and going into an operational mode, we decided to sit back and kind of try to see what came together that allowed us to have the success that we did in New Mexico and to develop a problem review system that we found to be so effective.

We right away knew that the broad elements that were needed were cooperation between the involved organizations. We have a long history in New Mexico of successful cooperation with the Title XIX State agency, the PSRO and the fiscal agent. We also needed data and looking at our MMIS data base we found a rich source of information. All we needed then, we realized, was the seed money to get going and this was provided to us by the Health Standards and Quality Bureau in the fall of 1976.

Some of the more specific things that we needed? We had to have the interest of physicians and this really was a key. In New Mexico again, we had the experienced physicians to really provide us with that kind of support. We needed core staff support. We performed the two-year demonstration project and all the studies that I've talked about with three full-time equivalents over two years.

Finally, we needed immediate and flexible access to the data base. When I say immediate, we really are getting immediate access to the data base. We're not getting any kind of standard reporting system. When we want to get something, we write the program, decide how much computer time it's going to use and then access the data; turnaround time is about one week.

It is important to note here that we don't have a routine report generating activity going on. We only pay for computer time when we actually want it.

What are some of the things that you don't need in order to do this? Standing outside the claims flow, the claims processing, and the claims review activity as we do, we find that you don't need changes in regulations.

We don't need waivers in requirements for claims payment time, for example, in order to get our review done. We stand outside that system and look at it from a distance. You don't need collection of new data elements. In the MMIS in New Mexico, we found that we had to be selective about what we chose, as a matter of fact. You don't need a large staff, as I mentioned.

Finally, you don't need an extensive physician consultant budget. We were able to use roughly half of the physician time we had budgeted, yet we found that physician time was being used efficiently and effectively by

calling them in at specified points in the process and having staff support provide the real ongoing activity.

What are the benefits? I've been touting the system. Let me talk about some of the broad ranging benefits of problem review. First of all as I said, we're outside the claims flow. We can stand back and decide what's a problem, take our time about it, select the problem that's most important to the PSRO, both to staff, to management and physicians, and also take our time in defining that problem.

We can then take our time and think about what the best opportunity for change will be. Dave mentioned some of our opportunities for change, including systems change, program change, PSRO policy change, and change in providers prescribing habits, for example.

Secondly, we're performing studies which are the basis for problem review, but it's important to note that we do them at the PSRO. We don't have an outside consultant coming in. We don't have a mandate from a higher authority telling us what we're going to study. We select it. Our physicians select it and our staff selects it.

We've mentioned the ability to study a broad range of topics. Quality of care -- of course, this is the big interest to our physicians. They want to know what's going on with prescribing drugs, for example, in the outpatient setting.

We have an opportunity to study utilization both on a specific provider or recipient level or as an aggregate study. We can study systems problems. I failed to mention that in our emergency room study we found, in looking at diagnoses, that we were reviewing a lot of diagnoses in our prepayment system that were always paid for. We didn't ever deny payment for them because they were always emergencies -- trauma, fractures, things like that. By eliminating those from review with an automated edit, we have eliminated about one-third of our claims volume.

Finally, we can make program policy changes. We can recommend changes to the State agency. Finally, I want to say that once the system is developed, and it did take us a year to develop both the review system and the data support system, it's self-limited in terms of cost and scope.

Thank you very much.

PACE: Utah's Approach To Physician Utilization

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MS. WASEK: Good afternoon. The purpose of my presentation today is to present the current as well as the potential use of the computerized system that we in Utah call PACE.

PACE has been used, historically, since 1975, for monitoring quality assurance of physician ambulatory care services. Even though PACE has been used extensively for this purposes, we are finding more approaches in other program management for its use.

We see PACE as a tool for both Medicaid program administration as well as PSRO. I hope to show you later on some of the examples of both applications.

As was stated, PACE is an acronym for Physicians Ambulatory Care Evaluation subsystem of Utah's MMIS. PACE has, historically, supported a program for physician ambulatory care services by the Utah PSRO. They have had primary responsibility for monitoring physician services under the Medicaid program in Utah.

Since UPSRO has been charged with exercising medical judgment and specifying peer review standards, the PACE system has proved to be an effective tool by providing a flexible means of communicating professional review guidelines to the computer system, which includes the ability to easily add or to change or to modify any existing guidelines. A guideline is somewhat similar to a SUR report and matrix combination, where the PSRO or the State can input logical sentences of review, and also have the ability to perform prepayment as well as post-payment review on Medicaid claims data.

After a year of operating in a prepayment mode, we selected to go to post-payment, as we felt that the review was just as effective and it avoided an inherent two-week delay in claims processing.

An additional capability in PACE is that of constructing patient treatment profiles, so that quality of care and utilization patterns could be observed over a period of time and evaluated in retrospect.

In addition, PACE has the capability of providing special evaluation reports or treatment profiles from the PACE history file to further support quality assurance monitoring. Examples of these would be the Medical Care Evaluation Studies, treatment practices for a particular diagnosis, or for a particular provider or client.

Perhaps an effective method for me to explain the approach that PACE uses is to compare PACE with SUR and/or SUR II, since many of you are somewhat familiar with the operating techniques of a SUR type claims monitoring. I am aware of the potential danger is doing this, in making this type of a comparison in a simplified form, but I think that it is probably the most effective way to explain to you how PACE works, since a lot of the discussion has already taken place on SUR and probably more to

come. We have felt that this differentiation between PACE and SUR is essential to avoid within our department any overlap or any duplication in review between SUR and PACE.

We're also involved in pursuing a PACE/SUR demonstration project with our Utah PSRO. We hope to identify or further evaluate any overlap or duplication of effort between the two systems.

We've been able to identify some user constraints that we've installed in selecting only proper types of guidelines out of PACE, as compared to what SUR could do more efficiently. And as I show a couple of examples later on, I'll try to bring that out.

We see PACE and SUR as two completely different systems, each with their own unique potential and capability of use. PACE, in our opinion, is a more client-oriented quality of care system with application for program policy monitoring of restricted services, such as client abuse detection, provider claim billing practices, or any other quality of care question. SUR to us is a tool for assessing patient abuse of services or potential fraud activity.

Again, PACE is a client-oriented system which employs automated screening guidelines. However, the PACE guidelines are presented in a format that is more clinically oriented rather than a statistical comparison.

This transparency represents an over-simplification of the PACE processing. I do have available some more detailed specifications of the data flow through the PACE system if any of you would be interested, but I thought this pretty much explained the process of the PACE system.

It is operated by the State, along with our MMIS system. PACE we operate on a bi-weekly basis. Claims processing writes warrants once a week. When we run PACE, we take the new claim data from MMIS, all of the guidelines that were developed, any specific study topics that were requested by the State Medicaid agency or PSRO and the PACE history file. They're combined and two separate processing cycles go on within that data.

I might say that PACE in Utah is working on limited data base, in that we have restricted the review process primarily to physician, hospital and pharmacy claim data. The screening would be performed for the guideline creation or for any special data requests; the outputs provided to the physician review in the form of management summaries.

I would like now to explain some of the differences, as we see it, between PACE and SUR. In PACE, all exceptions are based on user-defined criteria. In other words, it's a peer expectation of a certain delivery of service. In SUR, however, exceptions can be produced from user defined limits or from a claims deviation from a statistical norm.

PACE is not geared toward statistical comparison of services. In PACE the exception criteria can be defined over a period of time. The system has the ability to delay the screening of a potential exception for a specific time, until the guideline has been satisfied, with each guideline having the capability of its own unique time criteria.

In SUR, all exceptions are produced immediately, based upon the claim data available in the SUR history file. SUR, unlike PACE, does not have the ability to examine individual claims within a definitive time period.

In SUR, the exceptions are oriented more towards the total population of clients and providers with exceptions generated usually on much broader or less specific data.

PACE will review for the lack of an expected service. For example, if the State wanted to monitor for assistant surgeon charges without surgeon fees on the data base, PACE would generate an exception for each of these occurrences in whatever time frame was appropriate for your claim filing; SUR exception processing, whereas, is dependent upon actual claim occurrences.

PACE has the capability of also linking data from multiple claims type. In other words, it can link an ambulance service for a particular client with a medical service, or a physician treatment with a hospital claim, insuring that the hospital claim charges matched what the physician billed for. SUR, however, is dependent upon the data on a single claim form for exception processing. No interlinking of data from multiple claims is performed.

In PACE, the history file is accessed only for patients with new claims which are found to be subject to the screening. In SUR, the entire population of client to providers are referenced by exception criteria, and they are accessed in order to produce a statistical base in the user specified time frame.

PACE can only produce a very narrow statistical comparison upon request for a particular subject. It will not produce or provide potential guideline data to the user. SUR is much more capable to develop efficient statistical analysis of provider and client activity in multiple user defined report areas.

PACE maintains a history -- we find this is one of the unique benefits of PACE -- of every review activity performed on any particular client or provider in the period of our total PACE history since 1975. We find it very beneficial to know the history of a particular client or provider in the review mechanism.

SUR does not. Each SUR processing cycle is totally independent of past processing. All elements are recalculated at each run, and exception tracking is done on a manual basis external to SUR. It is our impression

that PACE is easier to manage in terms of volume of output than SUR, because a lot of the review is done on the front end by setting the type of guidelines, so when a guideline is accepted, the review has already been performed.

PACE is limited only to the data elements keyed into the MMIS system and the size of the reference file. The volume or the numbers of guideline sets available for review are not limited. SUR is limited to what is in the matrix. SUR, too, appears to have much more flexibility in that, but it also is limited to 200 matrix items in provider, 200 in client, and 200 in treatment analysis.

Client claims detail in PACE is decoded, it is organized by episode, and presented in a fashion similar to what you would expect in a medical record. The PACE patient treatment profile is readily interpretable for review or analysis. SUR claim detail reports or summarized detail on individual clients are organized by category of service and are in coded form. SUR, too, decodes certain key elements, but still retains its segregation by class groups.

Because PACE was developed by a physician review group, the system supports a review that is more analogous to a regular physician audit than does SUR. And to the extent that the Medicaid program administration is interested in quality assurance of the delivery of services rendered the Medicaid recipient, PACE is an invaluable tool. To the extent that the Medicaid program administration is interested in supporting an audit function, SUR may be of more value.

We have found with PACE an important vehicle for monitoring quality assurance, as well as abuse detection. From our experience we have found that in order to assess the potential of an abuse situation, it is much easier for the reviewer to analyze the pattern of care rendered an individual client as to what would be compared normal for that delivery of service. For example, if a patient on your history had two deliveries within a six-month period of time, it would be pretty evident that there is some definitive program action that is warranted.

If, however, knowing that a particular provider has exceeded his peers in the number of deliveries performed in a reporting period, still leaves additional analysis that is needed and possibly an on-site audit to determine if there is any adverse action.

One criticism that I have heard regarding this type of review is that PACE is too specific-oriented or limited in that it does not assess the universe of activity going on within the Medicaid client data base, and is solely dependent upon client capable guideline creation.

It should be observed, I think, that SUR, too, is highly dependent upon the care with which matrix elements are chosen. In our opinion, both systems require a high level of user competency and intuitiveness to

maximize the features of either.

However, we are intrigued with the possibilities of combining the best concepts of both, and this is the thrust of our current activity with the Utah PSRO. We hope to report to you at a future time to advise you of our results.

I would like now to go into some specific aspects of the use of the PACE guidelines in State program management.

This transparency shows to us one of the very unique features of PACE, the patient treatment profile. Maybe we can go through the circled letters. Up in the upper right-hand corner, A is the client identifying information. It identifies the client, the sex, the age, the client ID number. In B, we have the data service arrayed in data service order. C identifies the provider specialty providing the service, as well as his provider ID number. D describes the description of the diagnosis on the claim form; E, the diagnosis code. F is the diagnosis reference code that comes off our claim data, referencing the service that was provided to the diagnosis code.

Let me take the top example -- congestive heart failure in A. The office visit was provided primarily to support congestive heart failure, rather than the heart rhythm disorder. We find this is very valuable in that it arrays the services in order. It can be easily looked at. You will note on the bottom, in J, it identifies the guideline that was not met and the past history of this particular client.

Number 1, the client was reviewed in March of '76 for the use of propranolol with the history of congestive heart failure. It was reviewed by Reviewer 24, and there was an educational letter sent out to that provider at the time. Currently, the guideline that has not been met was that the client was provided two EKGs within a six-month period for a heart disease, diagnosis code ranges that we have inserted and assigned the number 0292. Like SUR, we have the capability of assigning one or multiple diagnosis to a group.

This is an example of the format of a PACE guideline set. It is different than the format in the SUR system. It is easier for us to understand. We assign a guideline number to it. We are asking the system to flag or identify any separate claims for Procedure Code Listing 084, and Procedure Code Listing 084 is our prenatal care, postpartum care, urinalysis, hematocrit, hemoglobins, office calls, office visits, unspecified office visits.

In other words, we are asking the system to tell us wherever we get separate bills for claims with those procedure codes, when a claim has been encountered for total OB care. We are asking the system to go back into history and identify an occurrence of a provider billing us a total global fee concept and billing us independently. This has been very

valuable. We have identified several occurrences, and this is an item that our claims processing system is not able to detect. In a global fee, the provider is required to bill us one fee for a total service.

Through PACE, we are able to identify inappropriate billing, and on this particular guideline, I believe a couple of years ago it led to the suspension from the Medicaid program of one particular provider who failed to change his practice.

We have identified some examples of PACE guidelines and how we find them useful in State program management. Jamie will go later into some of the guidelines that PSRO uses in quality of care, but PACE, to us, is a dual system. It serves both needs.

As we just discussed, PACE is valuable to us in recognizing double billing. We can screen for services, even multiple deliveries, where we have had providers bill us on different dates of service for the same delivery.

One of the more frequent we have identified is in the area of newborn care, providers billing us either on the day the baby was born or on the day the baby was discharged. Again, that is not something that claims processing can pick up, but that we do screen for through PACE.

Another area where PACE guidelines have been helpful to us is in the area of client misutilization. By developing appropriate guidelines as to the number of expected controlled substances or the number of expected drugs, we identify clients who are misutilizing services or potentially going from one physician to another physician, or pharmacy hopping.

A third area is one where we can look for misutilization by providers; the top one is where a PSRO has identified some physicians in the State of Utah who were abusing antibiotics for treatment of viral disorders. Because they have failed to modify their practice by letter, we have a guideline where a PSRO then refers to us any claims paid for this provider for that procedure, and we credit out the payment.

An interesting one when the new abortion regulations went into effect and we closed down payment for abortions, we found that one particular provider, who previously had been high in performing abortions, suddenly had an increase in the number of office calls that were being performed on women within a month.

Since we did not have policy guidelines to prevent payment to that provider, we asked the PSRO to screen for us the appropriateness of the frequency of those office visits. For many we have gone back and retracted from payment because they have not been deemed appropriate by the PSRO. Another area is for monitoring outmoded or unproven procedures. We have identified a procedure list of surgical procedures that are clinically no longer considered appropriate care. We screen, then, for any

of those occurrences.

Another aspect of PACE guidelines that has been valuable is in the area of client abuse. We have developed a guideline where we screen for multiple injuries to children under the age of one. Many times this is not identified by a particular provider, or the physician provider is hesitant to refer those to the proper authorities.

Now, in several instances, the Family Services Department in Utah has identified client abuse situations and has been able to remove the child from the home.

MR. CANNON: I have had an opportunity to present on a couple of previous occasions at IMM conferences, and some of you are familiar with a number of the things that we have talked about.

One way to talk about the PACE program is to talk about the gimmickry. This system that we have been involved in developing, that Optimum Systems, Incorporated, worked with us on, is a very interesting kind of a thing.

From the standpoint of a physician review process, it certainly has proven effective. We could spend quite a bit of time talking about that aspect of it, and we would personally find it interesting to do so, and perhaps you would get pretty fatigued in a short time.

But I think that one other thing we ought to say is another aspect of the program that is important. In fact, this has been implied throughout Sharon's presentation. This is the fact that the program works, not simply that the data system works and not simply that the data system produces information that means what it says it means, but that, in fact, the information is useful in terms of a review effort both on the physician side, the PSRO kind of activity, but also in support of State objectives.

I think that is important. One more thing about the gimmickry aspect of it, that may be helpful to you for those who have heard the presentation in the past about sort of the basic screening process that Sharon spent some time describing.

That is: the PACE system turns out to be useful for the State, not only because it can do a routine kind of screening, triggered by new claims, either an immediate sort of screening on data already in the history data base, but also, as mentioned, it provides a delayed screening process, looking for services that at the time the triggering element is observed, haven't yet been billed to the program.

In addition to that, the PACE system can select patient populations with specific characteristics for manual review. We define a data range and then we say one of the following: we want these specifically identified patients, we want patients of a specific provider or specialty , or we want patients with claims matching specified parameters, diagnoses, procedures, drugs, age and sex.

A third area is that the system does allow comparisons with other individuals or with a specialty, provider comparisons based on exception rates. And, then, fourthly, the PACE system allows utilization comparisons, either a specific provider to a specialty, the specialty's specialty, or among services, either in terms of raw frequencies of those services or drugs, or per patient counts; noting, for example, the median use per patient, or the 90th percentile use in an individual's practice.

It becomes difficult, and as I sat here listening, I was aware that if I were you, I think I probably wouldn't perceive entirely some of the nuances of the distinctions between the sort of thing that SUR does and the sort of thing that PACE does.

I won't try to belabor that anymore. You start with a patient and characterize the provider's practice based on what he does on a per patient basis is really at the heart of the PACE system, and derives from the fact that PACE was designed by a physician group concerned about patient care.

That gets me into the philosophical point I want to make. It's really the essential mission of the Medicaid program to assure that the patients, who are eligible for Medicaid program benefits, get the kinds of services they ought to be getting, and that, in addition we are not wasting our money, spending it on services that aren't relevant to the patient's situation.

In order to understand if the patient is getting what he ought to be getting, we have got to know what he is getting, and that ends up sometimes being a problem. When you are dealing with a large number of patients, a system is needed that actually characterizes patient care in a way that gets down to the ones where the patient care looks unusual, and, if the issue is one that potentially is a provider pattern, it is presented in a way that you can understand what the provider is doing.

So, the first point is, then, that in terms of your interest in PACE, the reason why it even ought to be talked about, is that for Medicaid program management, PACE does have some useful techniques that we recommend to you.

I think the second thing that makes it interesting is that it has been shown to work. We have a lot of experience now in Utah.

We have dealt with numerous physicians in the State. Our contacts have been associated with behavior change that we feel is substantial.

Let's deal first with the level of activity. You can see here the numbers beginning October '76, and going to June of last year; there have been approximately 3,000 cases studied on a whole variety of topics. Out of those evaluations, 1,172 letters have been sent.

There is a phenomenon occurring here that I will just take the time to observe. Through the end of '77, the ratio of letters to cases reviewed was in the neighborhood of one in four. By June of '78, the ratio of letters to cases reviewed was in the range of two to five, going from 26 out of 100 to 38 or 39 out of 100; the point being that as we learn, we are getting even more selective in terms of the cases we look at, and, in fact, are dealing more effectively with those, or at least are finding that the ones we look at are the ones we also want to contact physicians about.

A total of 575 different Medicaid providers have been contacted through those 1,170 letters. This represents us pushing -- since most of those are physicians -- half of the physicians that we have on the Medicaid rolls in Utah. The subjects involved totaled about 69. That counts as one subject -- all the patients we wrote about, who appeared to be misutilizing services, and about whom we notified the providers.

I think the other thing I should say is in terms of the actual effect of this effort. These contacts seem to produce a response. This may be evident on the next slide.

This was really quite surprising to us. The data have been reported elsewhere, and you may have run into them. Looking at a study of 100 physicians contacted during 1976, we found that 84 percent of them modified their behavior substantially on the specific topic of the contact. There were only the remaining 16 percent who didn't respond in any kind of significant way to the first contact. Those were followed up, and of those seven-eighths, 14 of 16 responded to the second communication. By the time we began denying payment, we produced a result in all of them.

It is interesting to note that on specific topics, just a few topics out of the large number that are dealt with, a result occurs. I think, finally, the other point would be that there is a real benefit in establishing a relationship with the physician community where they are involved directly.

New Mexico's presentation is very interesting in that regard, and there have certainly been some other things described that are very important in terms of how to involve the providers in the review effort. Certainly, that has been a strong point in our experience, that the PACE activity and the relationship to other aspects of the State's utilization control responsibility has not always been simple in Utah.

We are viewed by outsiders as having a very amicable sort of relationship, and sometimes we wonder how we are getting along as we deal on a day-to-day basis. But we find we have been able to work out problems and, although I am on the other side of the fence, I think it is fair to say that the Medicaid program in Utah has benefited greatly by the involvement of the medical profession in the activities, specifically in taking some of the heat off the Medicaid agency by handling a lot of this review responsibility and by dealing directly with the physician providers in the State.

There has been a certain amount of credibility that a Medicaid agency has trouble engendering with the profession, that a peer review organization sponsored by the medical profession can achieve. We find that accounts in part for that high rate of responsiveness to our contacts with the profession; that they have sensed that this is coming from a peer who understood, at least in some sense, their problems and was interested in what they were doing, and recognized that in almost every case the

physician was motivated by good intentions. To the extent that he was doing something that his peers didn't agree with, he recognized that his peers understood that, in medicine, there are 27 opinions for every 25 physicians, and he recognized that a dialogue could occur without immediate threat of sanction of some other sort.

So, our experience has been that this approach has proven useful and has proven a very interesting kind of process. We are grateful that we have been able to learn some things in the past few months as we have made a closer kind of study of the utility of PACE for the State system and in its relationship to SUR, that there are ways in which we can reduce some of the operating costs of running this kind of a sophisticated thing, and as well, that we have been able to identify some ways in which we really do see the potential of combining concepts from both systems.

We are excited about those possibilities and excited about learning from some of you your own experiences, that we may be able to implement here and share with you as we go on.

Data and Information Necessary for Management Control of Fraud, Abuse, and Waste

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MR. FERGUSON: Two points before I really get into this: first of all, we recognize we are playing into the cocktail hour. So, we assure you we won't drag on too long.

Secondly, neither John nor myself are really Medicaid program experts. As Dick indicated, I am a budget officer from the State of Washington in the Department of Social and Health Services which, among other things, administers the Medicaid program.

Really, my principal involvement with the Medicaid program per se has been as the director of business and finance at a county medical center, which is about a mile up the road, and is the principal teaching hospital for the University of New Mexico, and I believe was the principal deliverer of Medicaid services, at least hospital care, in the State of New Mexico. So, again my perception of the Medicaid program or my experience is mostly on the provider side, and, of course, John's principal involvement has been as a consultant to providers. So, neither one of us are experts in the Medicaid system.

In terms of the real thrust of our presentation, what we are really trying to address is the use of Medicaid management information at a policy level to keep the program from contributing to or forcing abusive situations.

The fundamental purpose is really threefold. Number one is to present a Medicaid management problem as perceived from the executive level of an umbrella agency. Secondly, it is to discuss the approach that we took to address this problem, and our observations of MMIS as a resource for assisting us in our effort. Thirdly, it is to discuss our plans for bridging what we perceive to be a reporting gap in MMIS as it relates to the problem. I would also like to make the point that this study is in progress. So, if you miss the punch line, it is because we are not really finished.

In terms of background, this effort started along about July, when I, as a newly arrived budget officer with a hospital finance background, was advising newly arrived top level management of an umbrella agency on the formation of a $2 billion budget for the ensuing biennium, and the budget spanned the totality of health and welfare programs, including health, welfare, child welfare, aging, voc rehab, developmental disabilities, mental health, adult corrections, juvenile rehab, and public health, among other things. In general, the objective was to produce a conservative budget reflecting some thoughtful approaches to restricting the growth of social and health service spending, which I am sure most of you at the State level have been involved in.

As we addressed the medical assistance program in this budget development process, two basic options surfaced in keeping with the idea of restricting growth. One had to do with continuing to finance the program, which obviously does not do too much to restrict growth. The other

option was to reduce the scope of services and/or eligible groups. From our perspective, again, as newly arrived people, both options proved to be unsatisfactory.

First of all, financing the problem was really not acceptable because of the implications for other departmental programs. The cost of financing the continued growth of the medical assistance program was pretty substantial when viewed in terms of the impact on such programs as adult corrections, juvenile rehab, developmental disabilities, et cetera. It would have forced disproportionate and unacceptable cuts in these programs.

In terms of reducing scope either in terms of people covered or programs provided or services provided, that was also unacceptable for several reasons. First of all, in looking at the scope of the Washington program -- which is a pretty broad program in terms of services provided and people covered -- we just felt intuitively that there were more options available for managing the program and limiting the growth than simply going in with a meat ax and reducing the number of people covered or reducing the number of services provided.

So, we didn't really feel that there were enough good answers or enough good analysis to really support that as an option. Secondly, we felt that most of the scope reduction options, whether they were recipient-related or service-related, ignored some of the fundamental relationships existent with the health care system.

For example, the idea of co-payment on primary physician visits came up. We didn't really feel that was too well thought out in terms of what the impact down the line might be, for example, the impact on emergency room visits. Another example would be restricting the scope of eligible people. Well, that is an easy approach to take when you are serving a number of optional groups. On the other hand, if you limit the coverage through Medicaid, you are simply contributing to the discounts and allowances, or revenue discounts that a hospital has to absorb. That gets passed back to private patients and really back to cost reimbursers through the redistribution of those costs, and that didn't really appear to be a very prudent public position to take in either respect.

So, we didn't really feel that any of the scope reduction options that were presented were legitimate. Our response was really to adopt sort of an interim step in order to prepare and present a budget, but more importantly, to launch a fairly broad study with the objective of trying to surface ways of influencing the medical care system without exercising arbitrary controls.

The study really had three major components. The first was the identification of short-term operational improvements, and this had to do with upgrading the surveillance utilization review activities, upgrading the activities of our medical consultants, which are really a pre-PSRO

type admission review.

The second area was the identification of long term policy options for restructuring the program, which really centered around approaches to: (a) reducing demand; and (b) adopting a more prudent buyer approach in terms of procuring services.

And, thirdly, and most germane to this meeting, is the development of a set of executive level reports designed to provide a comprehensive but digestible overview of the program on a recurring basis.

It was really in the second and mostly in the third of these components that we really came into contact with MMIS. In terms of our observations of MMIS as a resource for developing this set of executive level reports, our intent going into the project was probably somewhat naive, but we felt, given an overview of MMIS, that we could simply reach in and extract a set of information, and simply translate those into a more cosmetically appealing set of reports that would be of interest and use to the secretary of an umbrella agency responsible for making certain decisions.

In short, we were looking at sort of a short-term cosmetic type job. That was a fairly naive assumption as it turned out, because as we examined MMIS, we found a very well structured data base and what I would term a fairly neglected management level reporting function within the system.

The principal symptoms of this neglected reporting function were as follows. First of all, there appeared to be an informational gap. There was a myriad of detail to support or report on such functions as surveillance and utilization review, accounting information, bill processing, budget projections. Those types of detailed information were readily available, and there were a few pieces of very aggregate data readily available, but there was a real absence of regularly produced summary level type reports from which we could extract what we were really interested in.

We took the approach, of course, of requesting and obtaining some of these summary level reports, which were included in various portfolios of reports available. And as we reviewed these reports, we found what we considered to be the second major symptom of this neglected reporting function.

That was, first of all, a lack of general understanding or consensus as to what the reports meant, down to the detail that people could not agree or really explain the titles of various columns and rows that appeared in these summary reports. This is not to say that they have not been defined in the documentation supporting the system. It is just to point out that the managers supposedly using these systems could not readily identify what the report said.

The second point that we observed was the lack of confidence in the integrity of the reports, and it is the type of confidence that evolves from a regular use and continued refinement of the information that is in the reports. A principal example of this would be the inclusion or exclusion of patient days related to Medicare crossover claims. No one was quite sure whether they were in or whether they were out, or whether they were in in one July and out in the following July. So, it became fairly difficult to draw assumptions regarding the length of stay.

In fact, in our first cut-through, we felt that we had totally explained the problem in terms of a one-day increase in the length of stay. Well, we found out, in fact, that there had been a change in the reporting, and Medicare crossover days had not been included in one of the subsequent periods. So it caused a distortion in the figures.

One point in terms of the Washington system, the MMIS was installed in '75 and '76, and certified in '76. So, I don't think these problems really relate to shaking down a brand new system as much as they relate to a misallocation or an absence of allocation toward the management reporting functions of the system itself.

The approach that we are taking is to try to resolve this or bridge this problem, to clean the data, summarize it, and make it available in what we feel is a useful and digestible form to the top management of this umbrella agency and, first of all, to group the reports into basically three categories.

The first is demand, the second would be supply, and the third would be cost. We feel that it is important for making decisions at the policy level, that we have information grouped into these three areas.

The first has to do with a cost analysis, where we begin with what has been typically available, which is the cost per capita type information. We have tried to break this down into several additional layers to provide what we consider to be essential information, first of all, defining problems in the program and, secondly, making decisions relative to the program.

The general key again would be cost per capita. The second break would be by program component where we would actually break the cost per capita into the various subprograms like hospital cost, physician cost, et cetera.

The third layer down would represent key statistics within each program component such as cost per admission, length of stay, distribution of physician office visits between regular, intermediate, and intensive visits. Finally, a second layer of key statistics where within, for example, admissions, we would be talking about distribution of admissions between medical and surgical, time period comparisons of procedures and diagnoses mix, distributions of hospital costs between room and board, ancillary, and other.

As an example, if you were going down through this array and you found out that you had a situation where length of stay was constant but costs per admission were up substantially, it seems logical that the next thing you would want to look at would be patient mix and the intensity of care, and these types of second level statistics assist you in identifying those problems.

Now, going backwards and making that a full pyramid, of course, you would look at subprograms like the AFDC, medically indigent, that type of program breakdown, and identify on an exception basis whether there was any particular client group that was contributing.

The second set of reports is really what we would term a demand analysis, which attempts to take the general key, which is generally available, like the number of people eligible, the number of people using, and break that down further into what we would term first level statistics, which would give you utilization type, admissions, office visits, outpatient visits, emergency room visits; and then a set of second level statistics, which would provide you utilization patterns within admissions, for example, where you would look at number using and the percent of eligibles. And, again, back along the third dimension, we would look at subprograms and look at AFDC et cetera, to see if there was any particular contributing group.

The third key component in terms of management reporting at the executive level would be a supply analysis, and this, of course, is not, to my knowledge, readily available out of MMIS. I think it is important in terms of the number of providers certified and the number participating, and particularly in the hospital area in terms of the number of licensed beds, the percentage of utilization, any pending Certificate of Need actions.

I think these three analyses, cost, supply, and demand, at the aggregate level that we have presented, give you an opportunity to present in a fairly summary fashion to a chief executive of a large agency, a fairly comprehensive picture of the program and the components of the program that may be contributing to the problem. I think we could generate a little more useful discussion in terms of the types of policy options that might be available. With that, I would like to turn it over to John for his observations.

MR. KASONIC: I would like to amplify on what Bruce told you about our observations on using MMIS and developing it to its full potential. I am going to give you more or less the impressions of a management consultant who spends most of his time with providers, but still has a fair understanding of how the State agency that administers the Medicaid program works.

Now, the key components of our approach -- and I think most of the speakers today hit on it -- is the need to develop an understanding of the health care delivery system in order to appropriately manage the Medicaid program.

We talk about fraud and abuse. I guess I would rather not talk about fraud because that is easier to control than abuse. Abuse is subjective, but we know that abuse is a function of the amount of resources available; that if we have excess resources, then we are going to have increased abuse, because the capacity to deliver the service or the incapacity to deliver it will reduce abuse itself. Well, that is a delicate balance and it obviously gets into social priorities, and we didn't try to make any subjective judgments, but Washington does happen to be a State that does have considerable excess capacity in terms of health care services.

The first step in our approach was to get top management commitment. I guess you hear that for every project that you ever start on, that you have to have top management commitment. In this case it was absolutely essential because, as I will summarize later on, many of the problems had political implications. The Secretary of a single State agency is a political appointee of the Governor, and obviously, no matter how we want to address it, we are going to have to respond to the political system.

I don't know if Washington is unique -- but they have implemented a functional organization structure, and about seven or eight years ago when I looked at some other agencies, that was a very common structure. So, therefore, the Medicaid program officer has to buy his accounting services from Data Processing, his analytical services from some financial or program analytical group.

He doesn't have day-to-day supervision of all of his resources. So, we structured an integrated team. Bruce became the team captain, and that might be surprising to have the budget officer the team captain, but then we had people from all of the appropriate areas who understood the health system from their particular perspective and understood how the financing and operation of the health service delivery system worked.

The next step, which was a fairly important one, was to examine the data base of information we had available. So, we went out and looked at the MARS and the SUR system, and we looked at the accounting system, how the data flowed, how much was available, and what kind of client eligibility statistics, what kind of information we got from the PSRO, and so

forth -- what kind of information was available in order to design better management controls for the Medicaid system. We next thought that this probably wasn't a unique problem and that others had probably studied it so maybe we should review the literature.

We ended up abstracting several hundred articles on Medicaid cost control. Most of them were academic. Many of them were prepared from the perspective of the Federal government. Many of the studies were financed by the Federal government, Urban Institute, et cetera, and so the controls and perspectives were either academic or more oriented to how the Federal government should control and manage the Medicaid program, rather than a particular State.

And then they got very operational oriented, how to control drugs, et cetera. The next thing we did was undertake a review of what some other States had done, and to this end we just used the data that is available to everyone, regarding expenditures per case, et cetera. We also then made some telephone calls. We talked to some people with the MMIS group in Washington, some people that are here today, and we talked to some different State agencies who are using MMIS. We got hold of the GAO audit report, and went back to the first ones that were implemented. We talked to people in Minnesota, and so forth. If we were naive and neophytes in this area, perhaps others had already developed very sophisticated management information systems, and all we would have to do is adopt them for the Washington State program.

Well, that wasn't the case, and I will cover that later on. The next thing we did was focus our study. The Medicaid program in Washington is very broad. It includes almost all optional groups and almost all optional services.

We focused our study on the hospital area largely because that is where the bucks were and because that is where the biggest increase of acceleration in costs had occurred. We had actually had a decrease in the covered population by about three percent, and costs had gone up about 30 percent in one year.

We next took a look at the state of the art in technology, what kind of computer systems and software were available. We obviously talked to the EDS people. We looked at the system that Yale has, which will take a data base and manipulate hospital oriented information by diagnosis and secondary diagnosis, and so forth. There has been a lot of case mix kind of analysis conducted by the University of Washington group.

Next, we went through the data stratification that Bruce outlined for you, and I won't go through that, but we did it manually. We had analysts sit down and put together schedules of this kind of information largely in a constructive manner of trying to decide if this information, put together in this fashion with a computer, would be of any use to us. So, let's do it once manually and see if it is going to be usable. As Bruce

pointed out, at least it showed us that there were inconsistencies between the Washington State Hospital Commission on data and the MMIS, which were related to this crossover problem.

We then did an analysis of data relationships, and some of our analysis about length of stay and cost per unit were related not so much to the management reporting, but to those short-term solutions that Bruce talked about.

Well, those were basically the steps, and while Washington might be unique, I would say that based on my telephone conversations with about a half a dozen States, that they are not all that unique in the utilization of the MMIS as a management tool and that the whole process seems to be at an early stage of development, and that our conclusions resulting from our fairly limited couple of month's study might be useful to you.

I am sure in every area that there are limited resources. We have found that the MMIS, as a system, had just deployed all the resources of the Department. There wasn't a team or a surplus of physicians or analysts that could sit around and take a look at the output of the MMIS and make any kind of top level management information systems or reporting systems regarding it.

So that the operation, just running, getting the claims out, tended to consume everybody's time and no one really spent a lot of time looking through this system. We were only able to get program, fiscal and analyst type people to work on the project through the top level management commitment. They all had 20 other things to study in the agency, including juvenile rehab problems and adult correction problems and other things not related to the Medicaid program.

We quickly found difficulty to access the computer. You know, to get a report from EDS, it takes 30 days if it is not on the routine report. You want to get your own people to write a small program, to extract the data off of the accounting system. Well, it takes six weeks to get in the queue and six months to get the program, et cetera. So that the data we saw out there on the MMIS data base was not really accessible through the computer because the resources were already consumed doing other things.

The amount of data that we had to deal with was voluminous. Washington is a small State. They had 250,000 unduplicated clients eligible last year. They processed about 25,000 transactions a day through the MMIS system.

The data isn't 100 percent clean. We know that because the system doesn't get the feedback necessary to keep the data clean. Because we detected this problem with the crossover report, there will probably be some cleanup, but if it had been looked at every month, that information would have been detected at an earlier point. Because of the

excessive data, though, it is hard to get access to it economically. It is very expensive to process these. This is a small State. I suppose New York or California would just multiply this and probably in a geometric progression.

As Bruce already mentioned, the knowledge of the use of the MMIS was very limited. We were quite surprised to see how little the program managers really knew and understood the different reports that came out of the MMIS. That would have been fine if the budget analysts or the program analysts, or whatever would have understood the MMIS, but they didn't really understand the reporting system either, and had their own little schemes for devising the information necessary for management on kind of a reactive basis. We found the knowledge of health delivery wasn't what we had expected it to be, even in the program people. They have largely been claims processing oriented, get the bills in, get them processed, get them out.

They are insensitive to changes that Bruce talked about, where you put some squeeze on the primary physicians, and the next thing you know the emergency room is full, or you put some squeeze on the hospital and some other problem pops up in the system.

The orientation of the program managers and of the analysts, I think, in the agency has largely been reactive. They didn't view it as their role to sit down and think up what kinds of things top management would want in order to make policy decisions about the Medicaid program. Their job was when top management asked a question, to be able to respond in an intelligent and factual fashion, which they could do with all these detailed operating reports.

It left the problem of deciding what questions to ask to top management, and yet gave top management no reports to deal with this particular problem.

The rules and regulations we found were quite confusing. In Washington State we have these medical consultants that do prior admission reviews for surgical cases, and we have a PSRO, but we are not sure where the accountability is between those two groups.

The PSRO, interestingly enough, didn't produce any routine reports for the Department, and when we listed in a letter specific kinds of things we would like to have, which I think you would find fairly routine from Utah or some of the other States, they wanted $1,200 to produce the reports -- not a lot of money, but this does foster the idea of what is the accountability of the PSRO to one of the principal providers or payers for health care in the States.

Now, we do think that Washington is probably unique in the scope of its program. It provides nearly all services. Obviously, this will affect your unit statistics, and so things that might be good indicators

in Washington, might not work at all in New Mexico, where you don't have a medically needy program.

The organization of your government will obviously be a major factor as you would look at designing an improved use of the management information system. The single State agency makes it kind of easy. You only have to deal with one guy. But if the Medicaid program has to buy its data processing service from a Data Processing Department and its accounting services from the Comptroller's Office of a State, I am sure you are going to have different kinds of problems in terms of coordinating those resources.

We found the health planning functions are relatively confused in our State. The role of the HSAs versus the State Coordinating Council and the State Planning Agency is relatively uncertain. Washington hasn't implemented a law in this area, but these are the folks that control the amount of resources that are available.

When you have an average occupancy of 65 or 70 percent in your hospital beds, you are not going to get that under control until your population grows, which in Washington's case might be 25 years, or until you close some hospitals. And, you know, you are really coming down to that kind of judgment, and these planning agencies are presumed to move into that role, and yet their roles aren't all that clear.

In Washington, we have a State Hospital Commission that exacerbates the problem. They believe that Medicaid should pay the same price as everybody else. They see their role as a referee in the purchase of health services. They perceive that the Hospital Commission's role is to set the price, and then everybody pays the price that they set. Then they negotiate the price with the providers based on a review of their budget and the volume of services rendered; a different approach that is going to affect how Washington reacts to its management information needs.

Then, the PSRO in Washington functions probably different than the PSRO in other places, and, finally, we have a demonstration project that involves all the hospitals in the State. I won't go into the demonstration project, but certainly where you have a demonstration project in effect, you are going to need different kinds of management information in order to observe how well your Medicaid system is performing when you compare it to others.

We think the top level commitment is essential. The decisions that you make are going to be political actions that are going to affect the providers. It is going to affect their money. The Certificate of Need is clearly the most obvious. If you are going to cut out the number of CAT scanners that are authorized -- in this case, the single State agency has the Certificate of Need power -- you are going to find a lot of people down on the Governor's steps talking to him or talking to legislators

about their need for a scanner in their particular hospital, but obviously, we have to control them on a Statewide basis, not just in my hospital. So, if you are going to take actions that are going to result in those kinds of political reactions, then you have got to be ready to deal with them, and you can't do that unless the Secretary of the Department and the Governor and other senior cabinet officers are committed to making change.

Obviously, you need an integrated team. I think the problem, as it has been depicted here today and as you know it, is not the kind of thing that any one person can know all the facets. So, you are going to have to rely on the fiscal analysts and the computer system people and the program people to work together as a team.

Understanding the health delivery system is absolutely essential. It is fruitless to try to put in controls when you don't understand what you are trying to control. If you don't understand what the system's reaction is going to be to a new policy decision, then you shouldn't implement the policy decision.

Understanding the nature of your data base and how the information goes up the pyramid is obviously very important, and to be able to organize and relate the data to key variables is extremely important, and it has got to be done by people who know your setting and your situation.

You can't hire Dick Heim to design the perfect management control system and then just plug it in in New York or Connecticut or whatever. It has got to be tailored to your particular needs and your particular setting, your program scope, your management, your organization, et cetera.

You have got to be able to identify inconsistent data variations, and so you have got to be prepared to do that. Then you have got to be prepared to take decisive action when it happens. You have got to be prepared to take action that you don't want to take.

One little example: let's say that your nursing home industry feels that you are not reimbursing them on an appropriate cost reimbursement formula. That is probably a problem unique in Washington, but maybe others have it.

If you undertake a comprehensive study to examine the formula and you design what you believe is a conceptually sound formula, then you have got to be ready to live with the results even if it means you have got to pay more money rather than less.

So, when you go into these programs where you are going to get more information to make a program decision, once you get the information you are going to have to make the decision that tells you to. To try to decide what the answer is and then make the data base generate the information you want to justify that answer, is the way it has been done for

years. That is what the R & S section was for in most of the social and health services departments.

In summary, then, you are plowing new ground for Medicaid people. There is no easy answer. It is not in the literature. It is not in books, that you can drag it out. You are going to have to dig it out.

The data available from your MMIS system is excellent. There is no question but what unbeknownst to the government, they have now a latent data base of information about health care delivery services that national health insurance planners ought to be making full use of and probably aren't because of the level of detail and the editing, and so forth, that goes into the front end data.

Even though there are some problems with it, the data base that is available from the MMIS system is outstanding. The technology is available, and it is cost effective, and is getting more so. Pretty soon you can get a whole computer on that table that used to fill up this room, and you will get it for one-hundredth the price, and the price is going to keep going down. So, the technology is there.

The application of the technology to your data is not so easy because that takes organization, it takes people, it takes dollars, and those dollars don't show up on the budget as program dollars. They show up as administration dollars, and the administration dollars are pretty sensitive. We want to put the money out where the people are, where the service is, not in the front office where the administration is.

You have legal and regulatory barriers, and the Congress has seen fit to recognize these, and offer to waive them at least for demonstration projects. You have got social barriers. There is a natural conflict between the delivery of service and cost savings.

If we closed all the emergency rooms in Albuquerque tonight, we would save some money out of the Medicaid program. Undoubtedly, there would be some social consequences of that. Those are the kinds of decisions, not all of which are black and white, because as you move down the continuum and get into that gray area, then you are going to be making subjective decisions that trade off social gains for financial gains. You have these political difficulties that I mentioned before, your Certificate of Need and your legislature, et cetera.

We think that it is essential, if you are going to maintain the health resources out there for the Medicaid program recipients and you are going to get more service for the dollars you have available, that the only way you are going to get that is through more efficiency in the system. And the only way you are going to get more efficiency in the system is through better management controls so you can see where the soft spots are, i.e., the abuse, rather than the fraud.

Thank you.

Future Requirements

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MR. HICKMAN: I would like to speak to you this afternoon about the Medicaid minimum data set and bring you up to date with where we are on it and what is in it. I am pleased to report that we are moving forward with it.

We expect the package to be at the Office of Management and Budget about two weeks from now. It currently rests with the Report Clearance Officer in HCFA, who is starting to move it through the clearance process.

As soon as it goes to OMB, we will send a copy of it to you, so that you are aware of exactly what the reports are that we are submitting to OMB. Obviously, OMB has the authority to make changes, but I do want to keep you informed with the version as much as we know it.

The implementation date is scheduled to be October 1 of this year. We are hoping for quick approval through OMB so you have at least six months to gear up for it. With an October 1 implementation date, that essentially means that the first monthly report will be due at the end of November, 30 days after the end of the first month.

In addition to the actual preparation of the minimum data set and moving it to OMB, we have also been developing plans for technical assistance during the implementation stage. We are planning to have some of our own central office staff out in States, trying to make sure that there is clear understanding of the definition of the terms in the report, so that we are going to get consistent data.

We also will have available some contract resources and also plan to make use of some Regional Office staff, so that we will be available in the State with guidance on clarifying any questions about what is expected on the forms.

Let me move for a moment to what the items are in the minimum data set. Basically, the minimum data set is revision of the current monthly form, the 120, on which States report Medicaid data to HEW, and a revision of the annual form, the 2082. It also includes a substitution of a quarterly EPSDT report for the current EPSDT data that is reported on a monthly 120.

We are asking in the minimum data set what we believe are very basic data necessary for the management of the program and, really, the credibility of our being aware of what is going on in Medicaid. I would like to run through some examples of some of the data.

First of all, eligibles. We currently do not get any report on how many people are actually holding Medicaid cards. Beyond the obvious need for public accountability of how many people are in the program, the lack of this data obviously hampers policy analysis when we try to think in terms of changes to Medicaid eligibility policy, and are not totally aware

of how many people there are now.

We have recipient counts, and we end up in our analyses trying to plug some kind of a "guesstimate" factor of a relationship between recipients and eligibles.

Beyond just simply collecting eligibles, the minimum data set will change the classification of recipients. Currently, the data that are reported have really been designed to pick up Medicaid recipients in relationship to their public assistance status only, and have not really recognized the Medicaid structure of both a categorically eligible program and a medically needy program. So, in the Medicaid minimum data set, there will be breakdowns of both eligibles and recipients by these two categories.

Another major element that we don't collect now, that will be included in the minimum data set, are the number of claims processed. We hope to use a report on claims processing to improve our budget forecasting by getting an idea of the lag time in payment of claims and also some measurements of efficiency of claims processing by looking also at those lag times in terms of speed of claims processing.

Another element that will be included are providers participating in Medicaid, again, a very basic element of what the structure of the program looks like and what the trends are in the States in terms of provider participation.

We also will be looking at EPSDT accomplishments. For the first time we will be asking for reports on how many children actually get to treatment as opposed to the current reporting form which just picks up referrals, and, of course, has screens as well.

Also, recognizing that we are in the midst of a major Federal move to improve the immunization status of children, we think it is very important to, on the EPSDT reports, get information about the extent to which children are not immunized at the point at which they are seen in EPSDT, and the extent to which they come up to full immunization by the time the program has been through treating them.

Another element that will be in the minimum data set will be an improved basis for calculating unit costs. Right now we do get some units of service and we also get some expenditures by type of service, but there is no way to break out those expenditures to segregate expenditures for co-insurance and deductible. Obviously, if you just simply divide total expenditures by numbers of units of service, and some of those things in there are co-insurance and deductibles, that is not going to give you a very meaningful measure. We hope to correct that through the minimum data set.

We would also move towards picking up payments through health insur-

ance plans, so that we can make some comparison of States that are going through health insurance programs such as dental services, with costs in other States.

Those are really the major elements that you are going to see changed in the minimum data set. Some other elements are some changes in the racial-ethnic categories of eligibles to conform with OMB standards; a more specific breakout of types of mental health facilities, breaking it out between SNF/ICF care for 65 and over and inpatient psychiatric facilities for 21 and under; and the addition of rural health clinics as an expenditure item. The rural health clinic services have been introduced since the last report was put together.

We have been in the process of developing this minimum data set for more than two years now. We have had a number of discussions with States, both through the auspices of the State Director's Council, through the auspices of the APWA, and through formal submission of draft minimum data set to all States for a written comment. We have made a number of changes as a result of your comments. We think we now have put together a set of requirements that we can move ahead with.

I would like to give you some additional indications of what I think is coming down the road a little bit further. One thing is the need for data on performance in MMIS. There will be some categories of data, I am sure, that will be picked up on reports, and that is yet to be worked on.

The other item that I can project at this point is administrative costs. We currently are conducting a nationwide survey of administrative costs in the Medicaid program under the auspices of the State Director's Council. It was actually the recommendation of the State Medicaid Directors' Council at their last meeting that we do this sort of study because there is a lot of interest among States as to how people are allocating resources to various functional areas in the Medicaid program, and how one State compares with another in terms of number of staff and dollars spent in these administrative areas.

In addition to taking the results of this survey and feeding it back to States for their own purposes, we also will use this survey as a test of the methodology to be able to go on to an ongoing report in the administrative cost area.

Beyond these reports, we are thinking beyond the actual paper report form to an era of tape-to-tape sampling and submission of magnetic tapes, which I am sure will be appealing to those who have to worry currently about report forms.

MR. DOBSON: I am going to take a slightly longer view than many of the issues and discussions we have heard today. I come to you primarily as a data user as opposed to a data builder. I am an evaluator. I have been for nearly a decade now.

The way I got into the notion of tape-to-tape is in my attempts to use Medicaid data in the past. One of my primary responsibilities in the past few years was the PSRO evaluation, and as we tried early on to use Medicaid data in the PSRO evaluation, we were continually and thoroughly frustrated with that attempt.

As we have tried to do other evaluations with Medicaid data, from time to time we find that it is rather difficult to do. It became reasonably clear to myself and many others that it would be a useful thing to have a Federal system that sort of paralleled the system we now have with Medicare data, whereby with the Medicare statistics we have a central data file which we can access to do the many kinds of evaluations and mangement reports we would like to make.

What I would like to outline today is the logic of a future "tape-to-tape system." The purpose of tape-to-tape would primarily be to provide the States and HCFA with consistent program data which can be used to enhance management and development of the Medicaid program, and to enhance the analysis of programs which can only be evaluated with compatible Medicaid data.

The basic notion of the tape-to-tape system is to use the existing data elements in MMIS and variations that may be coming down the pike in the next year or so, to provide a Federal MMIS component, as it were. That is to say, data that we will have at the Federal level to do our work with. Clearly, State cooperation will be required, and it will be a joint effort all the way if we are ever to have the system from the majority, if not all of the States.

I think the primary use to the States of the system will be a comparative purpose: how does your State Medicaid system compare to other States in terms of use rates, beneficiary use, et cetera?

From the point of view of the Feds, I point out again that we will use it in an evaluative sense and a program management sense. The system will provide primarily expenditure, use, reimbursement and provider data in a consistent format to the HCFA and to other Federal agencies.

The system will be used primarily for policy analysis. That is to say, basic "what if" questions: the cost containment, management perspective, the components of expenditures, factors leading to changes in prices and quantities, so as to determine future expenditure patterns.

With such a system, we could perhaps look better at fraud and abuse, second opinion surgery activities, PSRO evaluation, EPSDT, sterilization,

abortion, and analysis of expenditures and use. Those would be the kinds of consistent analyses that we could provide at the Federal level, that right now we just simply cannot do.

The system will be based, as I envision it, on a series of rate analyses whereby we emphasize days of care and discharges for various providers, average length of stay, diagnoses and procedures, and then a whole series of descriptive statistics, patterns of utilization, who receives services, what is provided, and what does it cost, from a consistent level across all the States and at Regional levels.

In terms of the file structure, in a very simplistic sense, we would have a claims file, an eligibility file, a provider's file, administrative and analytical subfiles, and supplemental data, an area resource file, and master facility inventory data. We would merge those types of files as well.

The claims file would be the basic heart of the system, which would be, for the most part, based on individual unit records. We would have sampling frames, because, as you well know, I don't believe we would want everything for all of the components of the claims file system.

In the Medicare system, for instance, we have a 20 percent file, two 5 percent files, a 1 percent sample, a 40 percent sample, depending on what the issue is. And likewise, I expect, as we develop the claims file for the Medicaid data system, that we will take various files, depending on what the issue is and how much data we think we need for a given issue.

As I said before, we will look at total days of care, discharges, average length of stay, and those kinds of things for hospitals, and we will look at physician and other covered services, as well, and perhaps we could include claim statistics for those kinds of monitoring.

The eligibility file, right now seems to be the hardest one to come up with, at least at the Federal level. We will soon be asking for eligibility statistics. The eligibility file will be, from my point of view, similar to the Medicare enrollee file.

The primary purpose of that is to assist us in the calculation of rates. As of now, I think very few people have a consistent notion of what Medicaid use rates are from State to State, by region to region, et cetera; where, on the other hand, we have a very good notion of what Medicare use rates are. The primary distinction is, I believe, we have consistent data at the Federal level for the Medicare system, and we are able to calculate these use rates.

Without use rates, it is very difficult to do any substantive analytical undertakings at all, as we have found in the past. You are pretty much limited to average length of stay, number of services per benefici-

ary, et cetera, which I don't believe are particularly valuable or powerful from an analytical point of view.

I think we will have to puzzle at great length about what the eligibility file really means. I suppose that we will have to have an SSI, an AFDC, and a Medical Assistance only, or medically needy subcomponents, but Bill has been telling me that is a very simplistic notion; as we go from State to State, we will have to build up the eligibility file, because in various States, we define things differently. But sooner or later we have to come down on reasonably consistent definitions, so at the national level, I hope we can have an eligibility file that we can cut in different ways and make consistent analyses to the extent that that is possible across the States.

The provider file would primarily provide us with type of provider and service, characteristics of facilities, number of beds, et cetera, vocation of provider, and those sorts of activities.

In terms of the sequence for development of the tape-to-tape system, I think the first step is obviously today, preliminary discussions. Some of my folks have been here talking to you about the potential for doing this, and we have found that some of you are quite receptive to the idea.

Already initiated is the MMIS Task Force. My division will have some input into the development of the Task Force, and the notion of tape-to-tape will be something that we will be expounding upon as the MMIS Task Force gathers momentum in the upcoming months.

We will conduct a needs assessment, as it were, to find out what people, at the Federal level at least, really think ought to be in a tape-to-tape system. We will review the development and use of the Medicare Federal statistical system only because that is a system at the Federal level that we have been able to use, and make some analyses, the PSRO evaluation would be a case in point.

We will develop data elements because, as I said before, we will have to be constrained, at least in the near term, to what is in MMIS. It amounts to figuring a way to convert MMIS data into a system or tape format, such that we can use it in a consistent fashion at the Federal level. That will involve analyzing existing State MMIS systems to get some idea of the comparability of our needs and the data bases, as you have them, and your ability and our ability to cooperatively develop a system that you would be able to put on a tape format and render to us. Then, we could put out our reports and the descriptive statistics that we could feed back, and do the analyses that we would like to do.

We are now considering implementing the prototype systems in a few States, and I suspect that we will be back to some States in the not too distant future to ask for cooperation to try to develop and actually put

on line this tape-to-tape system as we envision it. As we work with a few States, I expect that we will encounter difficulties that were unforeseen, get a much better idea of the actual file structures that I have been discussing, and a much more precise notion of how we will actually use the system once in place.

After we have developed a few prototypes in States, then we will be able to go much broader and I believe to market, or sell, or cooperatively develop, however we would like to put it, the concept of tape-to-tape.

In terms of the time frame, I really don't have too good a notion of how long it would take to put this across in all the States or most of them. But we would like, within a year or so, to start our implementation in a few States to develop a few initial prototype systems.

I think I will conclude with just one remark. At least in my mind, the primary problem with most data bases is people try to answer too many questions. Everybody wants to answer something with data bases. Hence, they tend to grow like Topsy and really become basically unmanageable.

My guiding principle in thinking about tape-to-tape is to ask probably the impossible question: How can the system both be comprehensive and administratively simple? There may be no answer, but at least I will puzzle over that and keep it in mind as we work with you in the development through the MMIS Task Force and the initial prototype development, to keep the thing manageable so people can actually use it, because if it isn't usable, I just think there is too much bother to even fool with it.

Thank you very much.

MR. McDERMOTT: The favorite time on any program is the last day at the last hour, I guess. Actually, we are already at that point where we should be quitting. So, I won't take a lot of time, but the way I see this is sort of recycled.

Larry Levinson dealt with subjects that some of us, who have been around too long, remember having discussed earlier. In 1965, when the Medicare-Medicaid bill was passed, they had a small group of people in Washington to discuss how we could make these two programs work together.

The States suggested, first of all, that we adopt Social Security numbers as a common identifier. That was rejected by the Social Security Administration because it interfered with their claim number concept.

There was also discussion about hospital reimbursement and the need for some common approaches. Well, those came along later, but then when we got to talking about the common audit, we discovered that the common audit was considered to be an audit by the Bureau of Health Insurance with States helping to pay for it. So, some of those subjects, that we are now dealing with on a very amiable basis, have previously been discussed. Maybe as time passes, things will get better.

The way I see the future, as a State administrator, is responding more and more to direction as it is laid down to the Federal government. Larry's discussions sort of minimized the State involvement in these integration projects, although there do seem to be some committees of the State Medicaid Directors who are involved in discussions.

I am not sure that the discussions are as productive. Now that I have reacted to those things, I will carry out my own program assignment and discuss a couple of things that we are involved with.

One of them is timely claims processing. There is a proposed reg to implement a law that was to be effective July 1, '78, on requiring that 90 percent of clean claims be processed within 30 days. The definition in the proposed reg was a little bit different than the one Larry mentioned, in that it said that a claim would be all of the services covered by the claim on a given day, which is a little bit different than a line item. Of course, that is different from the Medicare definition.

It was not very liberal in the definition of a clean claim. It defined a clean claim as one that did not require any more written information from a provider or a third party. Now, there are a lot of other problems that you have with claims that could interfere with the processing that they didn't recognize.

As an illustration, there are the problems around eligibility where it is involved in a State-supervised, county-administered system. If the eligibility is not correct, it would appear that in order for you to stay within the guidelines, it would direct that you send it back to the

provider and let him straighten out the eligibility problem. Many of us were more accomodating and tried to straighten it out through our own files or intervention with internal department procedures.

That law, as well as the regulations, did exempt institutional providers from the regulations. So, that would not go into the measurement.

There is another new law on the books that you should be aware of, although I don't know that it is going to affect you directly, except as it relates to your relationship with contractors and providers. It is Public Law 95-559, the Health Maintenance Amendments of 1978.

There is an amendment to Title XIX that adds a paragraph into 1902. What that requires is, in the case of a State plan for medical assistance under Title XIX, that each State or local officer or employee, who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer or employee, and each partner of such an officer or employee shall be prohibited from committing any act in relation to any activity under the plan, the commission of which in connection with any activity concerning the United States Government by an officer or an employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by Section 207 or 208 of Title XVIII, United States Code.

What that means is if you are now involved in Title XIX, you will be treated as if you were Federal employees. So, you will be subject, under criminal penalty, to the conflict of interest statute.

I think those are the two important things that I wanted to discuss. The other less important thing is the rural health clinic law, which has been mentioned briefly. From a claims processing standpoint, that probably isn't as important as from a program standpoint.

In effect, by Federal regulations, Title XVIII is to pay an all-inclusive rate. The top limit on that is $27.30, but it is an all-inclusive rate regardless of what is provided in the rural health clinic. The rural health clinic is a clinic in a rural setting. It is under the supervision of a licensed physician, but it can be operated by either a nurse practitioner or a physician assistant depending upon what is permitted by State law.

It is possible under the Federal reimbursement for the supervising physician to not be on the premises. In some areas, I understand that there may be 20 to 30 rural health clinics under the supervision of one physician, who would employ a nurse practitioner or a physician assistant. In effect, the billing would be for that all-inclusive rate, which would include the service of the physician assistant, any lab services, any x-rays, or any other service provided by the clinic.

What the law permits is for Title XIX, in its plan, to either provide for reimbursement in that same form, or to measure the services under a different mechanism, as provided elsewhere in the State plan.

As I understand, most of the State plans that have been amended have picked up the Title XVIII provisions. If they also pick up the Title XVIII billing form, they don't have enough data to measure for EPSDT what a child is receiving and the tracking, and it also does not permit some other analysis of care in relationship to diagnosis to be done. All those are program decisions you need to be aware of. Thank you.

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